Population Services International (PSI)

Support for International Family Planning Organizations 2 (SIFPO2) Sustainable Networks

April 2014 – September 2015

SIFPO2 - YEAR ONE ANNUAL REPORT

November 15, 2015

USAID Cooperative Agreement Number AID-OAA-A-14-00037

Contents

Acronyms

ABC	Activity Based Costing
ACT	Artemisinin-based Combination Therapy
ADP	Accenture Development Partnerships
AYSRH	Adolescent and Youth Sexual and Reproductive Health
CAS	Cost Accounting Systems
CME	Continuing Medical Education
CMS	Clinic Management System
CoP	Community of Practice
DHS	Demographic and Health Survey
DHIS 2	District Health Information Software 2
DRC	Democratic Republic of Congo
E2A	Evidence2Action
EC	Emergency Contraception
ERM	Electronic Records Management
EVD	Ebola Virus Disease
FIGO	International Federation of Gynecology and Obstetrics
FP	Family Planning
GBV	Gender-based Violence
GHeL	Global Health e-Learning
HNQIS	Health Network Quality Improvement System
HTS	HIV Testing Services
ICFP	International Conference on Family Planning
ICRW	International Center for Research on Women
IMPACCT	Impact on Marriage Program Assessment of Conditional Cash Transfers
IPC	Interpersonal Communication
IPPF	International Planned Parenthood Federation
IUD	Intrauterine Device
LARC	Long-acting Reversible Contraception
LNG IUS	Levonorgestrel Intrauterine System
M&E	Monitoring and Evaluation
MSI	Marie Stopes International
OVC	Orphans and Vulnerable Children
PEGHT	Pfizer Executive Global Health Team
PEPFAR	President's Emergency Plan for AIDS Relief
PM	Permanent Method

PPIUD	Post-partum Intrauterine Device
PRH	Population and Reproductive Health
PSI/ASF	Association de la Sante Familiale
QA	Quality Assurance
QI	Quality Improvement
R4D	Results for Development
RH	Reproductive Health
RMNCAH	Reproductive, Maternal, Neonatal, Child, and Adolescent Health
SBCC	Social and Behavior Change Communication
SDI	Service Delivery Improvement
SF	Social Franchising
SFH	Society for Family Health
SIFPO1/2	Support for International Family Planning Organizations
SNHI	Single National Health Insurance
SRH	Sexual and Reproductive Health
TMA	Total Market Approaches
TOT	Training of Trainers
USAID	United States Agency for International Development
VMMC	Voluntary Medical Male Circumcision
VWG	Vasectomy Working Group
WHP	World Health Partners
YFHS	Youth Friendly Health Services

Executive Summary

PSI's Support for International Family Planning Organizations 2: Sustainable Networks (SIFPO2) leverages the multi-country private sector networks and internal systems strengthened under the first SIFPO Project (SIFPO1), to improve PSI's ability to deliver increasingly cost-effective and far-reaching family planning (FP) and reproductive health (RH) products and services within the context of informed choice. From 2014 to 2019, SIFPO2 aims to strengthen the total health market for voluntary FP/RH and other health services through two Results Areas:

1) Strengthen the capacity of PSI's network of members to deliver high-quality FP and other health services to target groups, and
2) Increase the sustainability of country level FP and other health programs.

This report describes the deliverables met by PSI and its SIFPO2 partners—Stanford Program for International Reproductive Education & Services (SPIRES), the International Center for Research on Women (ICRW), Results for Development (R4D), PharmAccess, and World Health Partners (WHP)—during this first annual reporting period from April 18, 2014, when the project was awarded, through September 30, 2015.

SR 1.1 Global organizational systems that strengthen FP and other health program performance improved, streamlined and disseminated.

Leading with evidence

- In recognition of the SIFPO1 midterm evaluation suggestion that PSI *"improve data for decision making,"* PSI organized a workshop to build the capacity of reproductive health (RH) program managers from seven countries to more effectively use data for decision making (Activity 1.1.6).
- The Social Franchise Network Management application within DHIS 2 has been developed, allowing users to run reports with multiple data sources (such as clinical services, quality assurance (QA), and training scores) in an easy to read format so that key decisions can be made quickly. This more effective and efficient use of data has also led to the development of a tool, the Health Network Quality Improvement System, that puts all this data into the hands of supervisors and managers when they visit providers, with greater information now available such as feedback scripts that are based on national or PSI clinical protocols (Activity 1.1.7).

Gender equality

- ICRW conducted a desk review of global literature on the relationship between couple communication and FP use, looking at the outcomes of programs designed to address unmet need by promoting couple communication and equitable decision making (Activity 1.1.11).

- To inform PSI/India's efforts to address gender-based violence (GBV), SIFPO2 assisted with the analysis of a survey of franchised providers in India and the design of activities to engage FP providers in identifying and responding appropriately to GBV (Activity 1.1.13).

Learning, sharing and replication

- This period has seen PSI contribute to many international forums on voluntary FP such as the International Conference on FP (ICFP) Steering Committee, the USAID Private Sector Working Group, the UCSF Global SF Metrics working group, FP2020 consultative networks and the UNFPA-USAID Total Market Approach (TMA) Working Group. Two briefs in development to be published in the near future include one on quality assurance, and another on FP/HIV integration in Ethiopia. Social franchising research in Kenya also yielded two one-page research summaries highlighting findings on social franchising and its association with uptake of long-acting reversible contraceptives (LARCs) and increased profit for franchisees. The next year will see an acceleration of such learning and sharing because of the groundwork lain in in Year One and because of some key dissemination conferences scheduled for FY 2016, such as ICFP and Women Deliver (Activity 1.1.17).

SR 1.2 Innovations, tools and approaches for delivering FP services to target groups tested, implemented and disseminated.

Expanding method choice within the context of informed choice

- In an effort to expand contraceptive method choice, PSI's network member in the Democratic Republic of Congo (DRC) laid the foundation for social marketing of Sayana Press in the DRC by conducting qualitative research with women and providers and by developing a marketing plan (Activity 1.2.7). The shipment of Sayana Press is scheduled to arrive in December 2015.
- PSI led an effort among a wide range of stakeholders to reduce and simplify the questions needed when using the Demographic and Health Survey wealth index (Activity 1.2.11).

SR 2.1 Financing mechanisms that improve sustainability of FP and other health services implemented or leveraged.

Financial sustainability

- PSI and R4D undertook domestic health financing landscape assessments in Tanzania and Uganda (Activity 2.1.2). For this first time, this revealed to PSI in these countries what opportunities exist domestically to partner with health financing mechanisms that will sustain FP and social franchising. In addition these assessments examined barriers to domestic resource mobilization.

This information is now in the hands of service delivery providers to act upon, as opposed to only in the hands of policy makers and health economists.

- The work to restructure and strengthen *Tunza* network in East Africa so as to increase efficiency, effectiveness, and financial sustainability of the network has been an early success story of Year One. Now the groundwork has been done, these countries will pilot their new business models starting in Year Two (Activity 2.1.5).
- A small project born under SIFPO2 has expanded into a global initiative that is central to the new strategic plan of PSI. This is the effort to transform PSI's accounting systems so that instead of funds being allied to projects, they become allied to new cost categories, such as products, services, and health areas for service delivery channels. This was piloted in Tanzania in Year One and is now rolling out to PSI/India (Activity 2.1.4).

SR 2.2 Capacity of local partners to provide high quality FP and other health services built.

Quality Assurance

- The new South-to-South Regional QA program was launched with a two-day interactive workshop in Washington, DC (Activity 2.2.2). This activity is now being enhanced through a review of QA tools in support of integrated service delivery (Sub Result 2.3).
- PSI shared the SafeCare QA approach with all of its social franchises in East Africa, and negotiated integration of this program in Uganda. In addition, PSI negotiated with PharmAccess to design a more sustainable long-term approach to funding and implementation of SafeCare (Activity 2.1.6).

Youth-friendly services

- PSI developed a Youth Friendly Health Services (YFHS) facilitation curriculum, which includes exercises piloted under SIFPO1 in Liberia, Uganda, and Malawi. SIFPO2 held a regional training of trainers to transfer the curriculum to the wider PSI Network in sub-Saharan Africa (Activity 2.2.5). Over time, these investments will have a huge impact on the quantity and quality of PSI's youth-friendly health services work, as well as subsequently on youth populations served by PSI.

Strengthen social franchising (SF) networks and their contribution to national health systems

- In addition to investments in DHIS 2 rollout, PSI has invested in increasing the capacity of its social franchises to measure and report against key, globally agreed, indicators of SF (impact, quality, equity, and cost effectiveness) (Activity 2.2.8).

SR 2.3 Innovative partnerships to strengthen health service delivery networks pursued.

- During Year One PSI has begun to developing an integrated QA framework to help health departments identify continued integrated opportunities for financial and human resource efficiency gains. The framework will be available by Q1 2016 with country piloting starting later in the year. The Health Network Quality Improvement System, a tool supported with SIFPO2 funds and described in this report, will be a key tool for rolling out this new approach (2.3.1).

SIFPO2 Year One Success Story

RESULT 1: Organizational capacity strengthened to deliver high quality family planning and other health services to target groups

Mainstreaming youth-friendliness in franchise networks across Africa

As the largest generation in history enters its reproductive years, serving the contraceptive needs of youth is essential to achieving FP2020 goals. Among married women, adolescents (15-19) tend to have the highest rates of unmet need for contraception. In some regions of the world, up to 68% of adolescents have an unmet need for contraception. In a recently published High Impact Practice (HIP) brief, USAID highlighted the effectiveness of mainstreaming adolescent-friendly elements into existing contraceptive services (USAID, 2015). SIFPO2 has provided PSI an opportunity to build network members' capacity to mainstream youth-friendliness in their existing service delivery channels in order to reach youth at scale.

This year, SIFPO2 supported the development of PSI's youth-friendly health services (YFHS) curriculum (Activity 1.1.14) and PSI's first ever regional training of trainers in YFHS (Activity 2.2.5). The one-week training workshop took place in September 2015 in Harare Zimbabwe, and brought together 16 English-speaking participants from 11 African countries: Angola, Burundi, Ethiopia, Kenya, Nigeria, Malawi, Mozambique, Tanzania, Uganda, Zambia, Zimbabwe. Cost share from other projects supported the participation of staff from several of these countries. One participant came from a partner organization, ChildFund/Zambia, and the remaining 15 were PSI network member staff.

Participants experienced the full, interactive YFHS training by undergoing all of the activities in the curriculum. In addition, participants refreshed their facilitation skills, learned how to plan for a YFHS training, and planned how to engage young people in the training. Every participant had the opportunity to practice facilitating YFHS training activities and receive feedback from the facilitators and their peers. Participants appreciated that the curriculum uses role plays, case studies, debates, small group work, and other participatory approaches instead of lecture.

All 16 participants committed, in advance of the training, to conduct at least one YFHS training of health care providers within 6 months of the workshop using their own project funds. In the month after the training of trainers, participants took a number of steps that were catalyzed by the workshop, such as:

- Incorporated YFHS training into existing provider trainings on LARC methods (Malawi)
- Met the Ministry of Health to compare YFHS curricula and gain buy-in for YFHS training (Kenya)
- Trained 26 staff under the Sexual And Reproductive Health for All Initiative Project (Zambia)

In Year Two of SIFPO2, PSI technical advisors will continue to follow up with participants and support the mainstreaming of YFHS through social franchise networks and other service delivery channels. In addition, SIFPO2 will hold a Francophone Africa regional training of trainers in YFHS.

PSI leaders from 11 countries and youth from Zimbabwe at the Training of Trainers in YFHS

SIFPO2 Year One Success Story

RESULT 2: Sustainability of country-level health FP and other health programs increased.

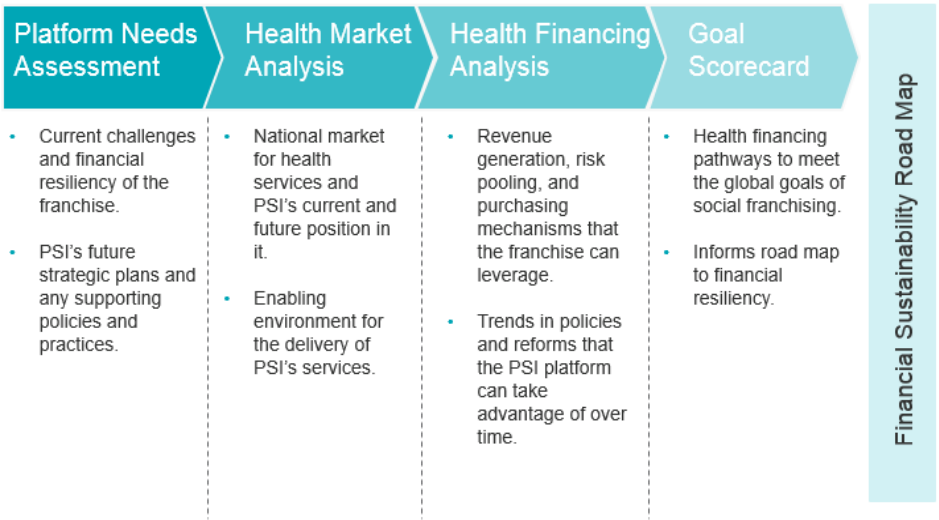
Enhancing financial sustainability for PSI's global franchise networks

The success of PSI social franchising in advancing quality FP services for underserved populations is vulnerable to reductions in external donor funding. To mitigate this vulnerability and ensure long-term financial sustainability, PSI and Results for Development are exploring domestic sources of financing to support franchising, whether they be financing for the work of franchisees or for PSI as a franchisor.

The first step on this journey required PSI in Washington and at a country level to be more financially literate and informed about domestic health financing. This is an arena that private sector providers in lower and middle-income countries have not frequently engaged with, in part because governments have frequently only seen health financing through the prism of generating funding for public sector services. It is in this sense, that these assessments can be defined as a milestone, a Year One success, although more results are expected to come from this work in further years.

Under SIFPO2, R4D has developed a *Framework for Analyzing Health Financing Options for the Sustainability of PSI Social Franchise Networks* that can be applied to examine financing opportunities and challenges for social franchise platforms in any context. This framework is illustrated below.

During Year One of SIFPO2, R4D and PSI **piloted the framework with PSI Network Members in Tanzania and Uganda** to deliver actionable options for financing franchise services, as well as to test the framework's flexibility and adaptability to country and platform contexts.



Progress highlights include:

- In Tanzania, the government's health financing strategy aims to unify existing public insurance programs under a Single National Health Insurance (SNHI) initiative. Against this backdrop, the franchise network must find ways to engage in discussions and developments around this strategy as well as understand the role of the private sector. R4D worked with PSI/Tanzania to identify strategies to strengthen and build their current skills to help enroll more franchisees and clients in public insurance programs and forge a link between private providers and the future SNHI.
- In Uganda, where immediate options for partnership with public insurance are scarce, R4D and PACE concentrated efforts on developing options for PACE participation in innovative financing schemes—such as a contract with the Kampala Capital City Authority and the new Global Financing Facility for Reproductive, Maternal, Neonatal, Child, and Adolescent Health (RMNCAH)—in which the Ministry of Health is a key partner.
- In both countries, the assessments helped build familiarity and comfort with the health financing language and frameworks for analyzing options within the platform to equip relevant staff with the tools to engage partners and stakeholders in discussions on financial sustainability.

- R4D helped identify and engage key stakeholders in the public and private sectors with whom the platform can collaborate to advance mutually-beneficial partnerships to strengthen franchise services.
- In Year Two, R4D and PSI will support these efforts in at least one more USAID PRH country, further support the operationalization of identified options with Year One partner countries, and work to evolve the discussion around health financing at PSI.

The *Framework for Analyzing Health Financing Options for the Sustainability of Social Franchise Networks* represents an important opportunity for PSI to focus on financial risk protection for Sara, an element that is key to the Universal Health Coverage agenda. By advancing the health financing options, which anticipate the needs of key stakeholders in the public and private sectors, PSI franchise platforms can position themselves as key partners in the implementation and scale up of universal health coverage.

Narrative Report for Year One

Result 1: Strengthened organizational capacity to deliver high quality FP/RH services to target groups

Sub-Result 1.1 Global organizational systems that strengthen FP and other health program performance improved, streamlined and disseminated

Summary of activities and outputs

1.1.1 Provide country-level QA training and supervision

Anticipated Year One Outputs

- In-country technical assistance provided in at least two PSI countries in addition to regular remote assistance

Year One Progress on Outputs

In January 2015, a PSI SRH technical advisor joined representatives from PharmAccess, PACE Uganda, PSI/Tanzania, and PSI/Malawi for a SafeCare study tour in Nairobi, Kenya. In Kenya, PSI's independent network member has implemented the SafeCare methodology across the *Tunza* network for over two years with positive results and practical implementation experience. The activity was designed to orient PSI Network Members in East Africa on a more integrated approach to quality improvement (QI) and included site visits and discussions with Tunza providers who are implementing the SafeCare standards. Following the study tour, PSI network members met to discuss the potential application of the SafeCare model to their QI systems, and how this could be integrated with existing PSI tools.

During the second half of Year One, PSI and PharmAccess developed a plan to pilot the implementation of SafeCare standards in Uganda or Tanzania during Year Two. The pilot will integrate the two QA approaches—one focusing on PSI's strengths in addressing clinical competency, and the other focusing on PharmAccess's broader view of clinic management. Much of the planning included a focus on ensuring the pilot included an emphasis on developing a cost-effective model.

Additionally, in late January 2015, a PSI SRH technical advisor conducted a training for managers of quality assurance supervisors in Uganda. The focus of the one-day workshop was on improving supervisor observation and communication skills in order to identify barriers to quality service provision

and develop clear, actionable plans with providers to address them. See Activity 2.2.3 for additional detail.

PSI has also provided remote support to PSI and its Senegalese Partner, ADEMAS, to prepare for the introduction of the levonorgestrel intrauterine system (LNG IUS).

1.1.2 Conduct QA external audits

Anticipated Year One Outputs

- Two QA audits conducted
- Two trained HCN staff co-led audits

Year One Progress on Outputs

SIFPO2 supported an external QA audit in Kenya along with the participation of the lead clinical auditor and an "auditor-in-training" from GreenStar, PSI's independent network member in Pakistan. The QA auditors found that the Kenya team has a strong program with high scores on many indicators of quality. They recommended improvement of supportive supervision through a more systematic approach to follow-up. (This need is being addressed through activities described later in this report activity, including Activity 1.1.7).

During the audit in Kenya, the audit team also used the opportunity to invite colleagues from the PSI Malaria and Child Survival department to join for two days to identify potential synergies for future integrated QA audits across health areas. The PS Kenya team plans to use these findings and test an integrated audit during one of their upcoming internal QA audits.

PSI/Mozambique's QA audit was postponed due to the need to provide the program with a more focused QA technical assistance to establish their service delivery system. This technical assistance is planned for early 2016. Two additional HCN staff from Mali and DRC co-led audits with separate donor funding.

During the project period, PSI conducted several activities to further develop regional staff capacity in quality assurance. In addition to the QARL training described under Activity 2.2.4, PSI has focused on improving its processes to ensure that regional staff participating in QA auditor workshops are able to put new skills to work soon after the training. PSI regional staff who take part in workshops are now fast-tracked to take part in a practicum (observing an external audit) and then co-leading an external audit.

During the project period, PSI has also refined the process for review and follow-up on external QA audits. Auditor reports and scorecards are reviewed by PSI's Global Medical Advisor and Global Medical

Director, who make recommendations to the country teams. Country teams are given a predetermined period to develop a plan to address any issues uncovered in the QA audit. Progress against these recommendations is monitored at a central level by the Medical Advisor and countries are scored on a global level regarding their responsiveness to audit recommendations.

1.1.3 Conduct a needs assessment to inform the development of PSI's Global Continuing Medical Education (CME) Program

Anticipated Year One Outputs

- Needs assessment completed in at least 10 PSI countries
- Plan based on needs assessment developed for CME program design and roll-out

Year One Progress on Outputs

PSI conducted a global landscape assessment to better understand ongoing CME efforts throughout the PSI network and across global RH/FP service delivery programs. The assessment reviewed CME approaches, inside and outside of PSI, to lay the foundation for an increasingly coordinated and global PSI approach to CME implementation. It also built on a needs assessment PSI conducted previously among PSI clinical staff and social franchise providers and considered the results of a rapid prototyping session where PSI explored ideas for new CME approaches. Some of the most salient findings from the assessment include:

- While it is not always defined as such, PSI's network members are already implementing multiple CME strategies, following internationally recognized best practices, using a blended learning approach that incorporates classroom trainings, skills training, regular supervision visits, and audits. In an organization such as PSI that has embraced the USAID Forward agenda and decentralized many network members, pooling this knowledge and experience is a very important exercise and precursor to coordination.
- Global trends and innovations in CME include integration of technology such as tablets, eLearning, and spaced education strategies.
- In many countries, there is a trend toward formalizing CME requirements for providers, although tracking participation and enforcement remain weak.
- Live lecture and in-person activities are preferred over an online/webinar format;
- PSI network provider motivation for CME exists independent of CME credit requirements;
- It is important to consider MoH strategy and liaise with them to deliver CME;
- There is variation in the quality of CME from the perspectives of providers.

The assessment provided the background PSI needs to design a centrally-born CME program under SIFPO2 that is easily integrated into PSI's existing QA/QI processes and integrated service delivery

initiative. In Year Two, PSI will explore integrating CME content delivery into supportive supervision and/or medical detailing visits utilizing low-cost tablets that are currently being piloted in East Africa.

1.1.4 Analyze research from SIFPO1 to generate SIFPO2 social franchise research agenda

Anticipated Year One Outputs

- Research agenda for SIFPO2 developed

Year One Progress on Outputs (October 2014 to March 2015)

In order to develop the appropriate research agenda to look more closely at social franchising in SIFPO2, a number of activities were undertaken. The research conducted on social franchising in Kenya under SIFPO1 demonstrated that client volume is higher and FP case mix more diverse when providers are members of a franchise, yet whether the services they provide are of higher quality is unknown. An assessment of existing peer-reviewed literature around franchising showed that although some studies on clinical quality within social franchises have been conducted, there is still a dearth of evidence on the effect of franchising and clinical quality.

Building on lessons learned from the social franchising research under SIFPO1 around the importance of early involvement in planning study design, the research team reached out to several countries currently conducting franchising operations to solicit buy-in for a research study on clinical quality in social franchising. PACE, PSI's network member in Uganda, expressed interest in participating in this research and meetings were held between the Uganda country team and PSI's research team in Washington, DC, to discuss potential study designs, obtain background information on the existing franchise, and identify potential barriers to address during the design process.

1.1.5 Provide global support to PSI network members for FP/RH clinical service data reporting

Anticipated Year One Outputs

- Technical assistance provided to countries as needed

Year One Progress on Outputs

PSI continues to expand the support and resources to FP/RH clinical data reporting and its aggregation up to a global level. Extensive technical assistance was required by network members during this reporting period to build their capacity to contribute accurately to PSI's new global Health Services Report, while many countries are also adapting to using DHIS 2 for the first time.

The new Health Services Report is a web-based, clinical service and referral reporting tool based in DHIS 2 launching throughout 2015, with different regions/languages coming on board in a staggered schedule. The new Health Services Report, supported by a number of donors including SIFPO2, gives users more control and flexibility to collect, report, analyze and visualize information. Migrating clinical service and referral reporting to the DHIS 2 platform allows PSI to expand the set of data that we collect on service delivery to meet industry and global best practices.

In July 2015, the Health Services Report was launched in DHIS 2 for French and Spanish network member countries to report clinical services and referrals data. All resources in the Help Desk such as articles, videos and common data elements definition were made available in French and Spanish. In preparation for the launch, a series of webinars were carried to ensure that end users were trained. Help desk agents fluent in French and Spanish are now part of the regular support team and thanks to SIFPO funding, regularly assist Network Members requiring assistance. After several months of reporting, the quality and completeness of the Health Services Report has improved significantly, translating into improved capturing and use of data.

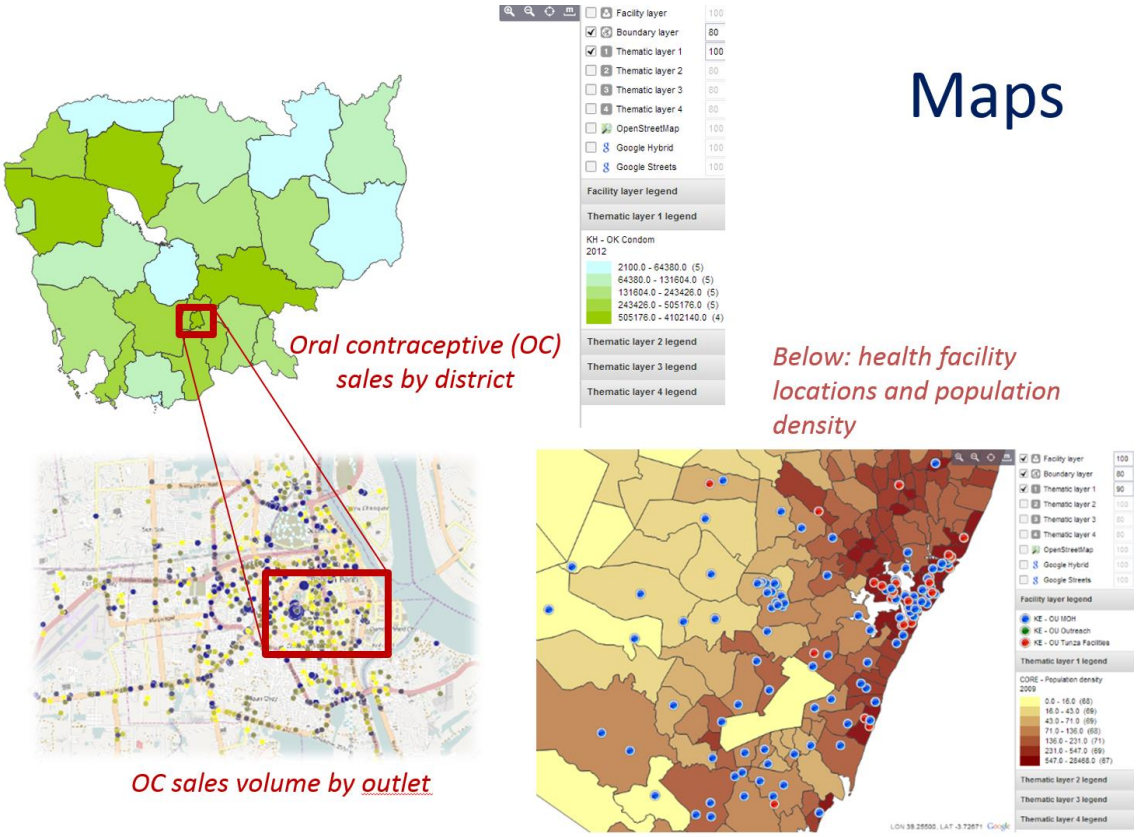
1.1.6. Improve country-level capacity in data for decision making and dissemination of results with key in-country stakeholders

Anticipated Year One Outputs

• Workshop held for at least 10 participants

Year One Progress on Outputs

In March 2015, in Nairobi, Kenya, PSI held a regional workshop to increase the use of data for decision making, involving RH program managers from Kenya, Malawi, Nepal, Nigeria, Uganda and Tanzania, as well as the Asia Region M&E Advisor. The “Data to Decision Making” workshop was described as a success story in the SIFPO2 semi-annual report. The maps below were examples of illustrations that showed program managers during the workshop the kind of data now at their fingertips, and how it can be used to improve decision making.



During the second half of Year One, PSI followed up with regional and country teams on progress made as a result of this workshop. The follow-up effort below was not funded using SIFPO2 funds, but illustrates the catalytic effect SIFPO2 core funds can have.

- The enthusiastic response to the workshop led to it being repeated by the participants for national teams in two different countries in Asia: India (July 2015), Cambodia (August 2015).
- A Do-It-Yourself "Data to Decision Making" training toolkit is currently being finalized, which all PSI countries can use to cascade the training down to lower-level staff in each country.
- Building upon an exercise from the workshop in Nairobi, PSI staff in West and Central Africa used a regional DHIS 2 training as an opportunity to conduct a mini-dashboard session with 13 participants (staff from Senegal, Mali, Côte d'Ivoire, Benin, Cameroon, DRC, and Burundi). A further training on Data to Decision is scheduled for PSI/Mali staff later in 2015.
- PSI held a 3-day training in Kampala, Uganda in June 2015 with 20 PACE staff with the aim of identifying what programming decisions they make, selecting the type of data they will use to guide decision making, and developing draft dashboards for their use. The team also developed a change management plan that is being implemented across their organization. The same process is scheduled for PSI/Tanzania in November 2015.

- The participants and facilitators of the workshop in Nairobi continue to share resources around the topic of "Data to Decision Making" such as free online courses in *Data Use and M&E* created for a PSI platform as well as webinars on data visualization.

All the above is a process; it may take time for these steps to be translated into measurable health impact, improved cost-efficiency or effectiveness, and even then, attribution will not be straight-forward. Improved efficiencies and effectiveness of PSI's work as a result of this activity will be forthcoming, as the foundation of good public health is good evidence and its effective use.

1.1.7 Create a social franchise dashboard tool within DHIS 2

Anticipated Year One Outputs

• Development of tool initiated

Year One Progress on Outputs

The first iteration of the Social Franchise Network Management app has been developed. The app allows the user to run reports with multiple data sources (like clinical services, QA, training scores) in an easy-to-read format so that key decisions can be made quickly. The developers will continue making the interface more user-friendly.

The next stage of this activity is to identify a SIFPO2 country to pilot the app, first by populating the app with the existing network directory and then by providing training to the social franchise managers to use and maintain the network directory. This tool has also been shared with Marie Stopes International (MSI), as they are interested in its usefulness and applicability.

PSI and MSI are now sharing and partnering on the use of this app. This collaboration was born directly from the collaboration fostered by USAID via SIFPO2.

The app has launched its second version, which now includes the ability to easily update geolocation information of facilities using Google Maps. This gives users the ability to accurately map facilities across large areas, without the need to document GPS points while in the field. The SF Network Management App will incorporate data coming from various data sources of DHIS 2.

Over the past year, PSI has been developing the **Health Network Quality Improvement System (HNQIS)**. This technology driven system is principally focused on enabling those responsible for supporting network service providers to:

i. Effectively **plan** their visits prioritizing where support is needed, and has most impact;
ii. Undertake **assessments** with comparable scoring and benchmarking mechanisms;
iii. Consistently and effectively provide **feedback** following quality assessments; and
iv. **Monitor** performance of providers over time to understand the return on their efforts.

HNQIS is tablet-based and can be fully functional without Internet connectivity. The system operates off an Android application linked with DHIS 2, a cloud-based information management system.

SIFPO2 funds contributed towards the development of the feedback module. This module ensures that provider feedback following a quality assessment is undertaken in a robust and consistent manner, rather than based on the subjectivity of the assessor. The module highlights the key areas of weakness identified during the assessment, and displays tailored feedback scripts, regarding how the procedure should be undertaken, as well as why it is important to do so. This places all the relevant information required to improve the performance in one place.

SIFPO2 funds were utilized to develop feedback scripts for each of the observation questions within the assessment checklist. In addition, the funds were utilized to cover system configuration and testing costs for the feedback module. Below is an illustration of the module's functionality.

Procedure	Observation	Pass/Fail
Provider correctly removes speculum	No	FAIL
When removing the speculum •Observe for any bleeding before removing the speculum. •Remove the speculum slowly, while inspecting the vaginal walls for any abnormalities. •Ensure that the speculum blades do not close before the speculum is completely out, as it can trap the cervix.		

STEP 1: Following an observation, the system automatically classifies the procedure as pass or fail

STEP 2: If the procedure was undertaken incorrectly, scripted feedback automatically pops up

HNQIS will be launched in Q1 of FY 2016 by PS Kenya to cater for their 309 social franchise providers. This will be followed by a launch by the Society for Family Health (SFH) in Nigeria (300 providers), and PSI/Tanzania. SIFPO2 follow-on funding will mainly be utilized to pilot the use of video-based feedback as a means of marrying HNQIS with supportive supervision and Continuing Medical Education (CME).

The HNQIS App will revolutionize the way quality assurance is performed by PSI's Network Members and will impact the way that Network Members plan, assess, provide improved feedback, and monitor and target resource allocation for their clinics. The HNQIS standardizes QA questionnaires, provides instantaneous feedback, tracks QA providers' performance and suggests how to distribute supportive supervision visits based on performance. Additionally, the HNQIS will link with the SF Network Management App.

1.1.8 Implement a client-based system via DHIS 2 in Nigeria

Anticipated Year One Outputs

• Implementation of client-based system via DHIS 2 in Nigeria

Year One Progress on Outputs

PSI's Nigeria network member, SFH, was selected as the alternative country for support after the original intention to provide this support to PSI/Haiti was unable to proceed.

A technical assistance trip took place at the beginning of Q2 2015 to assess SFH Nigeria's information needs and review M&E tools and their DHIS 2 configuration. At the time of the visit, SFH Nigeria was running version 2.10 of DHIS 2, which did not allow the use several key configuration and analytic features released on newer versions of the system. This was also being run on a local server. In conjunction with the local team, the decision was made to upgrade to the newest version - DHIS 2 2.20 - and migrate to PSI's global DHIS 2 server. That would allow SFH to receive immediate support from the PSI Global Help Desk team to troubleshoot issues in their system and to take advantage of the latest features and functionalities of the DHIS 2 system.

Several technical issues affecting the performance of the system, such as the slow internet speed and ineffective firewalls at the SFH office, are being addressed. The completion of the migration to DHIS 2's latest version on PSI's global server and the configuration for the voluntary FP program setup is expected at the end of 2015.

FP forms capturing data on DHIS 2 are being revised and information products such as reports and dashboards have been discussed and defined with the SFH Nigeria FP team and are currently being configured in the system. Currently, the data collected includes all services offered for FP and supportive supervision visits for QA.

1.1.9 Implement a client-based record system via DHIS 2 in one country

Anticipated Year One Outputs

• Implementation of one RH module of DHIS 2 in one PSI country

Year One Progress on Outputs

The first stage of the DHIS 2 support for Malawi was completed with the in-country assessment. The assessment looked at the fundamental processes currently in place to determine what areas need to be strengthened before moving to an electronic system.

During this reporting period, PSI/Malawi began the implementation of DHIS 2 to capture FP services data provided through the *Tunza* social franchise network. The MIS team supported the DHIS 2 configuration, pilot and user acceptance test before migrating the system to PSI's global production server. PSI/Malawi staff were trained on how to use the system to collect data, analyze it, and create useful dashboards. During one of the sessions, the local team created standard dashboards that were designed for access by various staff levels, such as field supervisors, program managers and QA teams. The ability for staff at different levels to access this information will facilitate improved understanding of trends and how to more effectively target program resources. In addition, the QA tools and workflow were reviewed to optimize content, scoring, and use of data to improve and standardize providers' feedback.

1.1.10 Design a research study to assess factors associated with contraceptive discontinuation

Anticipated Year One Outputs

- PSI network member selected for study participation
- Study design developed

Year One Progress on Outputs

After consulting with stakeholders during Year One, PSI concluded that given the studies planned or underway by MSI and the Population Council under the EVIDENCE project, as well as the resources available and competing priorities for Year Two, PSI has chosen not to undertake a further contraceptive discontinuation research at this time.

Instead, PSI has designed a study to further understand the wealth profile of clients at social franchise clinics, in comparison with clients of other types of clinics. The results from this primary and secondary data analysis will provide context to findings from various social franchises. For example, some findings to date have shown that clients served by social franchises may not represent the lowest wealth quintiles *nationally,* but more evenly spread across wealth quintiles when compared with others in urban and peri-urban areas.

Further analyses in Year Two can reveal what types of facilities *are* sought by those in the lowest two quintiles nationally. This may also yield insights on whether social franchising releases "pressure" on the public sector by providing health products and services to those with a greater ability to pay.

PSI remains very interested in the findings of the existing research on contraceptive discontinuation and will continue to engage with this field of research.

1.1.11 Conduct a desk review and qualitative field research in Zambia focused on couple communications about FP, with a specific focus on men married to adolescent girls

Anticipated Year One Outputs

- Desk review report that informs the design of a qualitative research study on couple communication around sex and FP decision making complete
- Field research report containing specific recommendations around approaches to increase male support for FP presented to PSI and other relevant stakeholders as well as disseminated electronically through global networks

Year One Progress on Outputs

ICRW conducted a desk review of literature on couple communication, with a specific focus on Sub Saharan Africa and South Asia, to address the following research questions: (1) What is the relative influence of spouses on each other's fertility and FP intentions and behaviors? How do differences in age, education, and occupational status impact these behaviors and outcomes?; (2) How have programs tried to improve couple communication and shared decision making to promote positive FP behaviors and generate support for women and girls who want to limit or space their births?; and (3) What has been the outcome of these interventions? Preliminary desk review results informed the research protocol development for a qualitative study on couple communication and FP in Zambia. In July 2015, the final desk review report was submitted to the USAID PRH Gender Team, which recommended that SIFPO2 adapt it into a "white paper" for publication and global dissemination. Leveraging cost share, ICRW will expand the internal desk review to make it available as a global resource in the form of a published white paper in Year Two.

In Year One, ICRW also finalized plans with PSI's network member in Zambia, the Society for Family Health (SFH), to conduct the couple communication and FP study in Central Province, focusing on couples in which adult men married adolescent girls (under the age of 18). This formative research study will inform SFH's programmatic initiatives geared towards improving couple communication about FP, increasing the reproductive agency of married women and girls, and promoting male support for FP in Zambia, in the context of child marriage. ICRW and SFH have worked closely to develop research instruments, map out research sites and recruit the research team. Qualitative data collection has been

delayed due to challenges in obtaining the necessary approvals for conducting a sensitive research study that includes participants that are minors and couples. The research protocol was conditionally approved by the ICRW IRB after a full board review in May (contingent on local ethical review board approval in Zambia), and modifications to improve the research design were submitted in September, in response to USAID feedback. ICRW IRB full board approval of modifications is pending, as is final approval by the local ethical review board in Zambia and the Zambian Ministry of Health. Approval by the Ministry of Community Development, Mother and Child Health was obtained in September. ICRW anticipates that all final approvals will be secured by the end of October, followed by the training of the research team, pilot of research instruments, and qualitative data collection to take place in November.

Given the complex approval process, ICRW has agreed with PSI the continuation of this activity and its conclusion in Year Two.

1.1.12 Conduct qualitative research in India focused on couple communication, with a specific focus on men married to adolescent girls

Anticipated Year One Outputs

- Revised study tools that generate information about couple communication and male perspectives on FP decision making in the context of a poor, rural setting in Haryana, India

Year One Progress on Outputs

ICRW reviewed and developed exploratory questions on couple communication dynamics to be included as part of the qualitative research planned under the USAID/PRH-funded IMPACCT study in Haryana, India. Probing questions were incorporated into the in-depth interview guides for married girls, focusing on decision making in the marital home, girls' knowledge of and attitudes toward and use of voluntary FP, and inter-spousal communication and attitudes toward GBV. The qualitative research was conducted in March 2015. Transcription and translation of interviews for the IMPACCT study were completed in May 2015 and analyzed in the following months.

Twenty-one case studies were developed based on the qualitative data analysis of interviews. Nine of these case studies were based on data collected from married girls and their families. In the interviews with girls, in part because they were married for less than a year and possibly because of their limited agency and voice, the questions concerning FP and couple communication did not yield substantial, in-depth data. However, the SIFPO2/ICRW research team will be reviewing closely the nine case studies and the transcripts of interviews with married girls and their families to help inform the couple communication and FP study in Zambia. For example, the findings and lessons learned from the IMPACCT case studies of married girls will provide valuable information for the refinement of the research tools, design of probing exercises for the training of the research team, and the modification of recruitment

strategies if needed. At the same time, the SIFPO2/ICRW research team will continue discussions with our IMPACCT colleagues in India to learn from their research experience in exploring these sensitive topics with young married girls.

1.1.13 Apply Provider Behavior Change Communication (PBCC) tools to improve health provider responses to GBV in one country

Anticipated Year One Outputs

- Select PBCC tools adapted for India to use in supporting providers to offer GBV screening services
- PSI/India staff trained to support their network providers to offer GBV screening services

Year One Progress on Outputs

In 2014, PSI/India received funding to address GBV from a PSI "*Women's Investment Network"* donor. To inform the design of the project, PSI provided remote technical assistance to PSI/India to conduct a literature review and formative research, including interviews with 32 OB/GYNs in PSI's social franchise. These providers were selected based on proximity to local NGO partners that will provide survivors with non-medical services. Providers reported a number of gaps in the knowledge and skills needed to address GBV. For example, although 69% felt confident they could provide emergency contraception (EC) to a GBV survivor who desired it, only 3% felt prepared to offer a referral for legal assistance. None of the providers endorsed any justification for intimate partner violence (IPV), but 43% regarded IPV as a private matter.

In September-October 2014, PSI SRH Technical Advisor facilitated a 3-day workshop for 32 relevant PSI/India staff to design the piece of the project that will engage health providers in identifying and responding to GBV. Several sessions during the workshop applied PSI's PBCC expertise to GBV services. Workshop participants used PSI's "adoption stairway," based on Prochaska's Stages of Change model, to segment the 32 survey respondents based on their current behaviors with regard to GBV identification and response. Staff also used the survey responses to develop a provider archetype and generate "value propositions" to encourage private sector providers to partner with PSI in responding to GBV (e.g., "By participating in PSI/India's program to offer a supportive response to GBV, you will gain knowledge, improve your clients' health, and improve your reputation as a trustworthy, well-known, preferred provider, which will lead to more business.") PSI/India strategized how to generate evidence to show providers that this value proposition is accurate (e.g., start with a small number of franchise providers who can serve as champions to encourage others to join the project). PSI presented the results of the analysis at an IGWG meeting in March 2015.

SIFPO2 has continued to provide remote technical assistance to PSI/India as they refine their plans to address GBV. PSI/India plans to begin training health care providers in the next year of the privately funded GBV project.

1.1.14 Develop a youth-friendly health services (YFHS) training facilitation curriculum

Anticipated Year One Outputs

- Facilitation curriculum for YFHS developed
- Support tools developed
- Materials translated into French and Spanish

Year One Progress on Outputs

PSI developed a curriculum for training health providers on youth-friendly health services (YFHS), which includes exercises piloted under SIFPO1 in Liberia, Uganda, and Malawi. The facilitator's guide draws from a number of published and unpublished resources developed by national and international organizations working to advance the sexual and RH and rights of young people. They include the International Sexuality and HIV Curriculum Working Group's *It's All One Curriculum*, the Institute for Reproductive Health's Gender Roles Equality and Transformation Project, IntraHealth, EngenderHealth, and Next Step. PSI ensured that the curriculum integrated gender considerations, including values exploration exercises (e.g., the activity "Act Like a Man" to examine the impact of rigid gender norms on health and well-being). In addition, the guide calls for the meaningful engagement of male and female youth throughout the five-day training. PSI's pilot experiences have shown that it is particularly helpful to have youth participate with SRH providers in role play exercises to allow providers to practice counseling real youth from their country and receive immediate feedback from those youth. The final day of the training takes providers and youth to a youth-friendly service site for a tour and a meeting with youth-friendly providers and their youth clients. The curriculum was further enhanced after a training of trainers was held in Zimbabwe (Activity 2.2.5) and it is now available to all PSI network members in English, French, and Spanish.

1.1.15 Develop the course "Introduction to Social Marketing" for the USAID Global E-learning site

Anticipated Year One Outputs

- "Introduction to Social Marketing" Global E-Learning course developed

Year One Progress on Outputs

PSI has completed the content development of the "Social Marketing for Health" global e-learning course with input from USAID colleagues from various offices including PRH, SBCC, Knowledge Management, and the Global Development Lab, along with a Foreign Service Officer. Fellow social marketing implementers such as Abt Associates, MSI, and DKT also contributed content to the course.

The course reviews the basic concepts of social marketing, such as, the 4 Ps (product, price, place, promotion), conducting a market assessment, gathering audience insight, and branding. The course also examines challenges to social marketing, monitoring a social marketing program, and the evidence to support social marketing as a high impact practice for family planning programs.

The course is in the final external evaluation stage. After incorporating feedback from the external reviewers, and receiving a final complete copy edit, the course will be published on the Global Health e-Learning (GHeL) site. PSI will disseminate the course across its global network, encouraging members to share the course with their Mission colleagues. PSI will find various outlets for external dissemination and publication including through the Knowledge Gateway, promotion at ICFP, and via PSI's website.

PSI has followed the GHeL Course Authoring Guide and has been in touch with the GHeL team to review how to follow their process and use the online system. A challenge has been the slow speed of the online system which has interfered with our ability to input content in the online format.

1.1.16 Participate in coordination meetings among SIFPO2 Prime partners (PSI/MSI/ IPPF)

Anticipated Year One outputs

- PSI SIFPO2 project staff participation in key FP technical working groups, consultations and meetings

Year One Progress on Outputs

PSI hosted MSI and the International Planned Parenthood Federation (IPPF) at the PSI offices in September 2015 for a half-day meeting that provided an opportunity to discuss strategic priorities and collaboration. Carrying on from where SIFPO1 left off, SIFPO2 recipients have continued to share and collaborate with a high degree of openness. In January 2015, all three partners joined a meeting with USAID and staff from the EVIDENCE project. This resulted in further sharing of priorities and work plans, and an agreements were made to:

- Share research methodologies and tools (e.g., tools to interview drug shop clients) to increase consistency and comparability of study results;

- Input into protocol design, to incorporate key research questions from different project perspectives where possible;
- Share interim results with other projects where possible, to inform on-going programming; and
- Convene of regular (at least annual) meetings to share updated research agendas and progress, and to discuss new areas for collaboration.

PSI met with MSI and IPPF for the Service Delivery Improvement Division's meeting of January 2015, with all partners presenting projects and work plans for the year. To discuss collaboration and future work plans, an additional side meeting was held of all the SIFPO2 Directors and Deputy Directors on January 26, 2015.

MSI and PSI both also collaborate closely on the USAID/UNFPA TMA working group, while both PSI and MSI also presented to the Private Sector Working Group in the first half of the year. During the second half of the year, MSI and PSI worked in partnership to prepare for a joint PSI-MSI session that will take place at ICFP.

1.1.17 Participate in international FP meetings and working groups to share PSI lessons learned and best practices (PSI)

Anticipated Year One Outputs

- PSI SIFPO2 project staff participation in key FP technical working groups, consultations and meetings

Year One Progress on Outputs

During this period, PSI actively participated in a number of key FP meetings and working groups. Highlights include:

- PSI attended the Reproductive Health Supplies Coalition meeting in October 2014, hosted in Mexico City. PSI served on a panel "Private Sector Solutions to Public Health Supply Chain Challenges" as a member of the Systems Strengthening Working Group and presented on FPWatch for the "How Large is the Private Sector" as member of the Market Development Approaches Working Group.
- PSI supported PSI/Madagascar to co-lead with IntraHealth/Madagascar a webinar presentation (in French) for the Gender Community of Practice (CoP) coordinated by Evidence2Action (E2A). The presentation focused on the Integrated Social Marketing Project's work to constructively engage men in FP/RH.
- As the secretariat of the LARC & permanent method (PM) CoP, PSI organized the new Vasectomy Working Group. (See Activity 1.1.19)

- In March 2015, PSI delivered a presentation to the Interagency Gender Working Group showcasing work supported by SIFPO2 to understand provider attitudes, needs, and biases with regard to GBV services in India.
- In July 2015, PSI participated in a meeting of the Social Franchising Metrics Working Group to refine shared metrics on market expansion (now called additionality), and definitions of franchise sustainability.
- PSI participates in the consultative FP2020 network and has applied for the market dynamics working group. (FP2020 is going through a strategic planning exercise and based on the results will move forward on working groups; thus, new nominations are on hold.) Rodio Diallo (Senior Country Representative, PSI Mali) participates on the Rights and Empowerment working group; Navendu Shekhar (Director, Evidence for Implementation, PSI) is active on the Performance, Monitoring and Accountability Working Group of FP2020.
- PSI supported the Marketing Director of ADEMAS to present on the introduction of Sayana Press in pharmacies in Senegal at the Sayana Press Technical Update meeting in April 2015.
- PSI participated in Women Deliver Advisory Committee meetings and the ICFP Steering Committee.
- PSI also serves on the mHealth Working Group, the USAID Private Sector Working Group, and UNFPA-USAID TMA Working Group.

1.1.18 Participate in a Reproductive Health Supplies Coalition (RHSC) Annual Meeting and on-going working group meetings

Anticipated Year One Outputs

- Participation in the RHSC meeting in October 2014 and subsequent working group meetings

Year One Progress on Outputs

In October 2014, PSI participated in the annual Reproductive Supplies Coalition Meeting. PSI presented during various sessions including presentations on the role of SF in health system strengthening as well as the importance of demand creation in a TMA. Throughout the year, PSI is also an active member in several RHSC working groups including the Market Development Approaches Working Group, the Systems Strengthening Working Group and the Francophone Forum SECONAF.

In the second half of the year PSI undertook a scoping exercise to assess the feasibility of the RHSC's Take Stock campaign, which aims to reduce stock outs. PSI committed to measuring stock outs with the Universal Stock out Indicator to assess the frequency and magnitude of stock outs (with a view to dramatically reduce the frequency, duration and number of methods stocked out). This will be achieved by incorporating this indicator the "supportive supervision" aspect of the "Health Network Quality Improvement System" that PSI is designing, piloting and rolling out using SIFPO2 core funds – this is the

tool PSI staff worldwide will use to guide their supportive supervision and collect and manage data relevant to supportive supervision.

1.1.19 Lead LARC & PM CoP

Anticipated Year One Outputs

- At least two technical consultations held through the LA/PM CoP, including one with a focus on youth

Year One Progress on Outputs

In its new role of Secretariat of the LARC & PM CoP, PSI hosted a Technical Consultation entitled "Putting the Family Back in Family Planning Exploring & Expanding Men's Use of Voluntary Vasectomy" in February 2015. The meeting was organized in collaboration with USAID/PRH's Gender, SBCC and SDI teams, and brought together a cross section of partners, including thought leaders, implementers, service delivery organizations, and social and behavior change experts. The consultation explored current vasectomy programming successes, challenges, and opportunities, and gave partners the opportunity to share ideas for new programming models and reinvigorating efforts around this important contraceptive option.

PSI, in coordination with USAID and JHU-CCP, initiated the formation of the Vasectomy Working Group (VWG, a sub-group within the LARC & PM CoP) in 2015. The VWG held its first meeting in July 2015 with participation from a range of implementing organizations and USAID colleagues. Participants developed a terms of reference for the working group, and brainstormed objectives and activities for a draft work plan. In October 2015, the VWG met for a second time to solidify the group's vision and work plan for the following year. As immediate next steps, the group decided to host a webinar on vasectomy, support World Vasectomy Day, and will start working in the small groups that formed around the three main result areas (advocacy, knowledge management, and in-country implementation.)

In collaboration with FHI360, MSI, Pathfinder International and its E2A Project, PSI hosted a symposium titled "For Youth, A Healthy Option with LARCs." The symposium gathered more than 100 experts from around the world—including program advisors and implementers, researchers, young people, health providers, donors and advocates. With opening remarks from Ellen Starbird, Director of the USAID Office of Population and Reproductive Health; a keynote presentation on the Contraceptive CHOICE Project from its principal investigator Dr. Jeffrey Peipert; a dynamic interview and passionate call to action from young Liberian radio host Massa Harris; and experts from both the U.S. and country programs posing challenges to the audience and inspiring debate; the room was filled with excitement, curiosity, and a determination to get things done. During May 2015, the organizers hosted a small, high-level meeting for a select group of technical and field experts to continue the discussion, in order to: 1) provide the

evidence for a global consensus statement on the safety and efficacy of voluntary LARCs for adolescents and youth; and 2) develop a set of recommendations for research, program and policy, that respond to the questions discussed at the symposium. The consensus statement will be launched at the International Federation of Gynecology and Obstetrics (FIGO) and ICFP conferences this year, and is being led by Pathfinder and E2A. The report from the symposium, with recommendations, has been developed and reviewed by the partners and USAID, and is now being designed for dissemination via PSI's website and at ICFP. A series of blog posts about the event was also posted on the PSI Impact blog.

1.1.20 Provide a training for SIFPO2 partners in PSI's problem-solving approaches

Anticipated Year One Outputs

- Two-day workshop for SIFPO2 partners held
- Participants understand PSI's PIP process Participants can apply PIP techniques to SIFPO2 project planning and to solving program challenges within their own organizations.

Year One Progress on Outputs

Staff from three SIFPO2 partners attended the PSI "Performance Improvement Plan" workshop in May 2015. This included staff from PharmAccess, Results for Development, and ICRW. (A fourth SIFPO2 partner, WHP, was invited but unable to send a representative.)

During the 4-day workshop in Washington, DC, participants:

- Learned how PSI addresses performance issues large and small, from management issues to strategic thinking;
- Strengthened skills as an effective facilitator of meetings and trainings;
- Gained the knowledge, skills and confidence to solve problems with creativity, innovation, and collaboration.

Following the workshop, SIFPO2 participants reported using the skills they honed in multiple ways:

- For PharmAccess the feedback was: "the workshop has been useful as we're continuously updating our approach to meet current needs, and we regularly design innovative solutions to increase the impact of our approach. The workshop has equipped us to respond more effectively to rapid growth, and a highly dynamic environment by getting the best out of our team. Also, it's been a pleasure to work closely with one of our key partners on topics of our mutual interest and concern."
- The participant from ICRW informed PSI they facilitated a workshop session in Kenya to help partners come up with a common set of indicators, using the techniques acquired at the training.

1.1.21. Transform PSI Mozambique FP program design based on Movercado/SMS data

Anticipated Year One Outputs

- Movercado data analyzed to inform FP programming

Year One Progress on Outputs

In Mozambique, the modern contraceptive prevalence rate is only 12% and almost a third of married women have an unmet need for FP. To address this unmet need, PSI/Mozambique operates a network of nurses under the brand name "TEM+," which means "we have more." Promoters lead interpersonal communication sessions in the community and offer electronic referrals to TEM+ through basic SMS technology, enabling real-time tracking of the effectiveness of referrals and better use of data for decision making. Through the program, funded by three European donors, PSI/Mozambique has developed a database of thousands of phone numbers of women who have expressed an interest in FP and have given consent to receive text messages and calls.

This year, SIFPO2 supported PSI/Mozambique conduct a survey of women enrolled in the telephone database to measure client satisfaction and understand the behavioral determinants of seeking FP services. Operators at a Quality Control Call Center held brief telephone interviews with 3,844 women (aged 18 to 49) who had accepted an e-referral to a TEM+ nurse from promoter in the past year (August 2014 to July 2015) in four of PSI/Mozambique's intervention areas: Maputo, Gaza, Inhambane, and Sofala provinces. One third (34%) of these women had visited a TEM+ nurse for FP services and the other two thirds did not follow up on the referral. PSI/Mozambique used chi-square analyses to compare these two groups and identify differences that could explain why some women utilized TEM+ FP services while others did not.

After analyzing the results of the first telephone survey, PSI/Mozambique conducted follow-up interviews with specific subsets of participants to explore their answers in more depth. As a third step, PSI/Mozambique held focus group discussions in the four provinces to gather qualitative data to explain key trends and correlations identified through quantitative analysis of the telephone surveys. In the first quarter of Year Two, PSI/Mozambique will finalize their analysis and use the findings to inform their marketing plan for 2016.

Preliminary findings have already been used to inform PSI/Mozambique's programming decisions. Two examples are presented here:

1. Among 560 survey participants who had no intention to use FP before meeting a TEM+ promoter, 18% visited TEM+ nurse for FP after speaking with a promoter. Women were most likely to change their minds in favor of FP if they met the promoter in their home with female neighbors and/or female family members present. Having these key members of their social circle present

during interpersonal communication sessions may have provided the women the information needed to consider modern FP methods acceptable in their communities. PSI/Mozambique has advised promoters to spend more of their time conducting interpersonal communication sessions with small groups of women in their homes rather in venues like marketplaces, where sessions were less effective.

2. PSI/Mozambique uses multiple models of service delivery including seven TEM+ clinics that charge no user fees for FP. Women are much more likely to choose LARCs in the clinics without any user fees than they are in the 20 TEM+ clinics where users pay for a range of prices for FP methods, with LARCs as the most expensive methods offered. In focus group discussions and interviews, participants explained that they see price as a barrier to accessing LARCs in the clinics with user fees. These results have led PSI/Mozambique to reconsider their pricing structure to ensure that all methods are financially accessible to clients.

The large dataset obtained from this research will continue to be analyzed to study segments of clients, improve program design, and explore opportunities for additional and improved health services based on the needs of clients.

Participants in a focus group discussion led by PSI/Mozambique

Sub-Result 1.2 Innovations, tools and approaches for delivering FP services to target groups tested, implemented, and disseminated

Summary of activities and outputs

1.2.1 Undertake a total market analysis of FP in one country (TMA)

Anticipated Year One Outputs

- Market analysis conducted in one country

Year One Progress on Outputs

Senegal was selected for the first TMA for FP in Year One, based on the availability of recent quality data and strong government support of voluntary FP. PSI's TMA framework was adapted for voluntary FP and the potential market in Senegal quantified, with a focus on showing the gap between use and need among urban and rural women.

Supported by the PSI SIFPO2 team in Washington, ADEMAS (PSI's local affiliate) and local stakeholders were advised on how to undertake a total market landscaping. ADEMAS subsequently gathered information from key players in the value chain, from importers down to providers and a research consultant was hired to support in mapping of the total market. All this work was done in close partnership with the FP Division of the Ministry of Health.

The analysis produced in Q4 will be discussed internally and then externally in the next reporting period (Year Two of SIFPO2). The Ministry of Health suggested the final analysis will feed into Senegal's 2016-2020 FP Action Plan and will be overseen by the national voluntary FP steering committee within the Ministry of Health.

1.2.2 Develop and refine criteria for most suitable environmental context for deploying telemedicine interventions in rural areas

Anticipated Year One Outputs

- Criteria and assessment tool developed

Year One Progress on Outputs

In an effort to test approaches to increase access to FP and other health services to rural populations, PSI and WHP explored the expansion of telemedicine in sub Saharan Africa. WHP staff first developed a list of any potential data needs that might help facilitate the process for identifying suitable intervention candidate locations and then produced country profiles. With these country profiles, senior staff within WHP would be able to work with local country experts about priority market failures and determine how and if WHP's model could be adapted to meet the local needs. WHP developed a standard question guide for developing a country profile, modeled after the "Making Markets Work for the Poor" model supported by DFID.

1.2.3 Identify at least three USAID priority FP/RH countries in sub-Saharan Africa most suitable for telemedicine intervention deployment

Anticipated Year One Outputs

• Three countries identified with detailed recommendations and methodology justification

Year One Progress on Outputs

Based on activity 1.2.2 WHP refined the approach and explanations of the telemedicine model for PSI, paying particular attention to the alignment between WHP and PSI models. This information was shared with PSI and reviewed via conference call with WHP President. Subsequently, PSI made an introduction to PSI/Tanzania that resulted in:

- An exploratory conference call between PSI/Washington, WHP leadership, and PSI/Tanzania.
- WHP being included as a sub-grantee in a PSI Tanzania grant proposal on maternal health. The proposal was submitted in early August and WHP have not received any updates yet.
- Plans for an in-person meeting in Dar es Salaam.

WHP/Kenya's Technical Advisor, who was part of the original WHP team in India, subsequently spent a week with PSI Tanzania in early October to further introduce the WHP model as beneficial to the PSI/Tanzania approach. The trip was deemed productive by PSI/Tanzania staff and the providers who had the chance to experience telemedicine approaches, and there appears to be potential for collaboration between PSI and WHP in Tanzania. The teams are now in process of determining the next steps.

If PSI/Tanzania and WHP agree upon a way to partner that marries the FP priorities and financial sustainability priorities of SIFPO2 with PSI/Tanzania's *Tunza* social franchise, then a partnership will be proposed for Year Two.

PSI also introduced WHP to PSI/Zimbabwe, but this introduction did not yield any action. To that end, WHP and PSI have agreed to focus efforts on continuing the dialogue with PSI/Tanzania and are holding off on identifying additional potential countries.

1.2.4 Develop metrics for measuring the outputs and impacts of telemedicine interventions

Anticipated Year One Outputs

• Provisional metrics developed

Year One Progress on Outputs (October 2014 to March 2015)

WHP staff developed a preliminary metrics framework based on discussions with WHP M&E experts and using components of WHP's existing telemedicine metrics systems. Though this preliminary metrics framework is complete, WHP believes further development is necessary in order to improve usefulness. WHP anticipates improving the preliminary metrics with a results-based framework that will clarify assumptions and hypothesis about the practicalities of introducing a telemedicine intervention to FP/RH programs and/or a social franchise. WHP will then use the resulting framework to develop a log frame that includes the metrics, their definitions, means of verification, and recommended frequency of collection.

1.2.5 Develop an analysis and strategy for telemedicine intervention scale up in Kenya

Anticipated Year One Outputs

- Analysis of WHP's program in Kenya and recommendations for scale-up

Year One Progress on Outputs

Using the funds from the Skoll Award for Social Entrepreneurship in 2013, WHP has implemented its telemedicine network pilot in Kisumu and Siaya counties of Kenya. The pilot had some success in demonstrating both the potential and usefulness of telemedicine to allow rural, underserved Kenyan communities to access high quality healthcare services. In the next phase of its network deployment, WHP planned to create a network of rural telemedicine providers in Homa Bay County. Discussions were undertaken with PS Kenya on linking the network with existing *Tunza* clinics in the county, however the parties were unable to agree on a way to partner in Kenya, with PS Kenya having questions about the model and the financial assumptions, and how these fit with the *Tunza* network run by PS Kenya. Therefore, the discussions between WHP and PS Kenya were not taken further. This informed the review of the business model and partnership discussed in Activity 1.2.3.

1.2.6 Conduct a literature review on the value-added of telemedicine to the uptake of FP/RH services at the rural level

Anticipated Year One Outputs

- Technical brief developed

Year One Progress on Outputs

WHP staff and research assistants have completed the first phase of the telemedicine literature review. All relevant data has been pulled from over 100 articles on telemedicine and recorded on a standard data recording form. Salient findings from these data were collated a summary report was produced by WHP.

1.2.7 Provide technical assistance to PSI/Democratic Republic of Congo (DRC) to launch Sayana Press

Anticipated Year One Outputs

- Select PSI-DRC network providers trained to provide Sayana Press
- QA system expanded to include Sayana Press provision
- Communication materials enhanced to include Sayana Press

Year One Progress on Outputs

In an effort to expand contraceptive method choice, PSI's network member in DRC, the Association de la Santé Familiale (PSI/ASF), is preparing to offer Sayana Press through its social franchise network and community-based distribution by authorized health workers in Kinshasa. The USAID Mission is donating commodities in support of this activity. (The shipment was scheduled to arrive in June 2015, but had not yet arrived at the end of the project year.)

To lay the groundwork for Sayana Press, PSI/ASF took a number of steps using SIFPO2 core funds. Each step was conducted in collaboration and coordination with the Mission, the MOH, and Tulane University, which was leading a pilot study of community-based distribution of Sayana Press.

- **Formative research:** PSI/ASF conducted qualitative interviews and focus group discussions to understand women's, community health workers', and franchise providers' views of existing injectable contraceptives and the possibility of community-based distribution of Sayana Press. The research revealed a number of barriers that PSI/ASF will work to overcome, including widespread rumors about the health effects of injectable use, concerns about delayed return to fertility, and male opposition to use. The findings contributed to the decision to request core funds for a constructive male engagement campaign in Year Two of SIFPO2.

- **Marketing planning workshop:** The research informed a workshop to develop a social marketing plan for Sayana Press using PSI's "Delta" process. The workshop, which took place in June 2015, was led by Fatima Ndiaye, the Marketing Director for ADEMAS, PSI's independent network member in Senegal. Fatima shared her experience with the social marketing of Sayana Press in Senegal thus far and guided the group through decision making around the four P's of marketing: product, price, place, and promotion. Following the workshop, PSI/ASF made the decision not to over-brand Sayana Press, based on a number of considerations and guidance from PSI's Global Marketing Director.

- **Coordination with Tulane University:** PSI/ASF's quality assurance staff in DRC assisted Tulane with the training of medical and nursing students as community health workers for their pilot

study with Sayana Press provided by UNFPA. PSI/ASF will use the results of Tulane's study, which ended in October 2015, to inform its upcoming Sayana Press work in DRC.

- **Preparation for Field Support Funding:** PSI worked with the USAID Mission to develop a work plan for SIFPO2 field support funding that will support Sayana Press distribution via community health workers and social franchise clinics. The field support funding is expected to start in December and will supplement the funds rolling over from PSI's core budget from SIFPO2 Year One.

1.2.8 Develop provider support materials for dedicated Postpartum Intrauterine Contraceptive Device (PPIUD) inserter

Anticipated Year One Outputs

- Provider aids developed and disseminated
- PSI post-partum intrauterine device (PPIUD) training materials and protocols revised to incorporate the new inserter

Year One Progress on Outputs

Under SIFPO2, PSI has revised its PPIUD insertion protocols to include the new dedicated inserter, along with existing protocols for forceps insertion. The new protocols draw upon those used for the USAID Saving Lives at Birth demonstration project in India and have been integrated into training materials. These were further refined following a training of trainers conducted by PSI's Global Medical Director in Mali, and converted into a simplified job aid with an easy-to-follow checklist.

PSI is also working with Laerdal Global Health, maker of the "Mama-U" post-partum uterus model, to include footage of the inserter in a new introductory video. PSI will make use of this footage in subsequent sensitizations and trainings.

1.2.9. Increase access to post-partum FP through the introduction of a dedicated PPIUD inserter in Mali

Anticipated Year One Outputs

- MOH authorization obtained
- Pilot sites selected
- Training of Trainers (TOT) conducted
- Pilot site providers trained

Year One Progress on Outputs

Following Mission concurrence in May 2015, PSI/Mali worked with a consultant to review protocols and training materials, and organize a training of trainers for PSI and senior MOH staff. In August 2015, PSI's Global Medical Director traveled to Mali to conduct an orientation for senior MOH staff, and training for 8 PSI and MOH trainers. As participants were already familiar with PPIUD insertion using forceps, an abbreviated 1.5-day training that combined practice on models and a clinical practicum at a pilot site was sufficient for providers to achieve competency. The training was very well received by MOH and providers, who were enthusiastic about the ease of use of the new inserter.

PSI/Mali was able to leverage complementary donor funding to purchase inserters which will allow for training roll out beginning November 2015.

1.2.10 Increase access to post-partum FP in Northern Haiti

Following discussions with USAID Haiti, this activity was not undertaken and a new activity was undertaken in its place with approval from the SIFPO2 AOR (1.1.21).

1.2.11 Revisit the measurement of equity, as pioneered by the DHS surveys using a list of asset questions

Anticipated Year One Outputs

- A recommendation regarding the adoption of a shorter asset list. Should the analysis favor a shorter list, the output will include a formal write-up of the methodology and findings, as well as a series of consultations with stakeholders. Other stakeholders will then use the short list to revise the equity toolkit currently found at www.sf4health.org.

Year One Progress on Outputs

In recent years, various PSI and other programs have incorporated the wealth index from DHS surveys into their client surveys and household surveys to determine the percentage of their clients or community populations that fall into each national wealth quintile. This has helped them to better understand if they are serving the relatively poor in their country or not. The original length (30-60 questions) and complexity of the questionnaires are being simplified.

PSI led a consultative meeting with colleagues from other agencies to agree on a strategy to simplify. In preparation, four alternative versions of the wealth index were analyzed as a starting point for the discussion. Each alternative removed different parts of the original wealth index in order to simplify it.

Based on these alternatives, the group was able to discuss and identify the priorities and parameters for the new wealth index. The key points were:

- Ease of use and simplicity for the programs conducting the surveys and the respondents answering the questions were the most important ways that the wealth index should be improved (as opposed to, for example, standardization of the questions across countries).
- Difficult questions such as the number of hectares of land the respondent's household owns or very detailed questions about the type of toilet the household uses must be removed or simplified.
- Knowing whether respondents were in the top two quintiles, the middle quintile or the bottom two quintiles was the priority.
- The new index should agree with the original wealth index in terms of assigning respondents to the top two quintiles, the middle quintile and the bottom two quintiles.

A fifth alternative wealth index was created according to the group's recommendations. This new version requires 6 to 18 questions depending on the country, and the questions are dramatically simpler than the original questions. On average, there are 66% fewer questions. The group agreed by consensus that the new index is the best alternative, and the process of creating this index was standardized such that it is replicable across countries and rounds of a survey. The new version is reliable for both national and urban populations, with the same survey. These findings have been written and submitted for publication to PLOS ONE, and are being incorporated into an online tool.

The simpler and shorter set of questions will make the measurement of equity easier, quicker and more affordable for programs, both within and outside of PSI, helping programs more precisely understand who they are reaching, and measure equity more frequently. A broad uptake of the simpler DHS wealth index program metric would mean that programs have comparable data on the extent to which they are reaching the poor. Comparable data on equity across organizations will be particularly useful for donors interested in understanding the how total markets impact across wealth quintiles extent to which interventions are reaching the poorest people in each country.

1.2.12 Develop a regional market assessment for PSI in South East Asia

Anticipated Year One Output

• A regional market assessment and external briefing report.

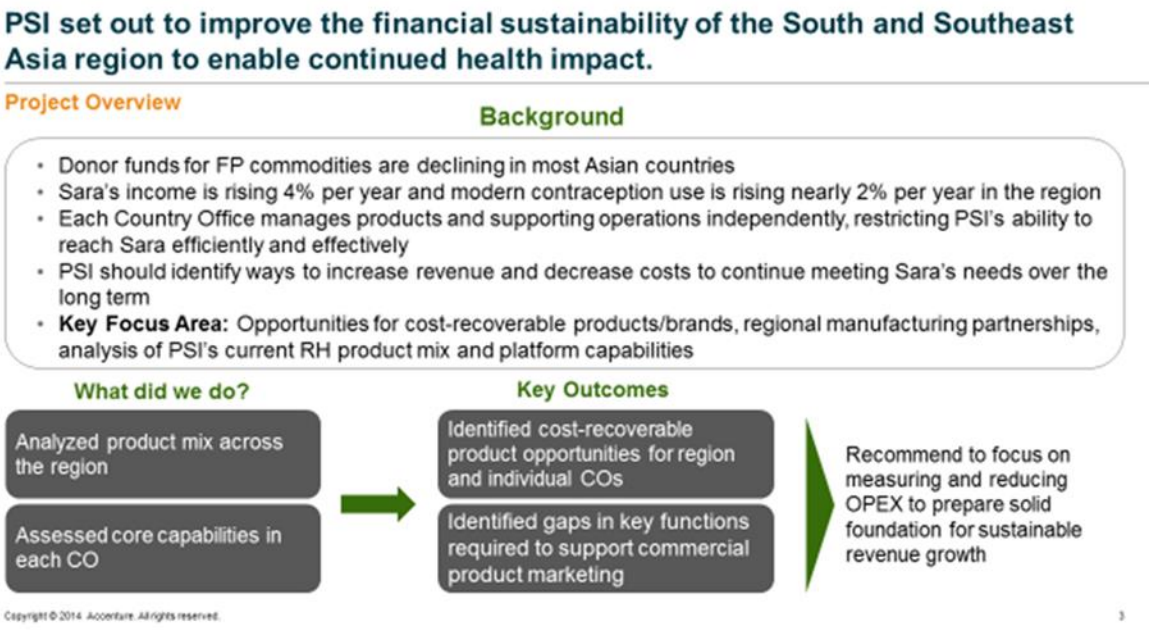
Year One Progress on Outputs

In December 2014, PSI and Accenture Development Partnerships (ADP) began an assessment looking at the total market for FP products and services in the South East Asia region, highlighting inefficiencies (within PSI and externally), and clarifying how to respond to these opportunities to better serve the FP needs in the region. This activity was cost shared with other donor resources.

This activity was undertaken because while PSI's social marketing campaigns and longstanding FP products have helped address unmet FP needs in South East Asia, market changes, national government changes in policy or financing, and new donor modalities have placed constraints on future FP subsidies in the region despite continuing unmet need. Donors and governments are demanding more adaptable FP business models that react to new trends and demands, and work efficiently within existing national and regional markets and financing frameworks. The assessment was undertaken three phases.

- The first phase was a regional market assessment was completed during December 2014 and March 2015.
- Phase 2 involved clarifying the most strategic options to carry forward based on the assessment.
- The third and final phase of this activity involved "finalizing a regional business plan for PSI and a roadmap for action."

Figure: *An illustrative example of a slide describing the phase 1 assessment*



Below is a sample of the recommendations from the Phase 1 initial analysis. These are included in this report for illustration and without the accompanying evidence that ADP produced to substantiate these recommendations.

Recommendations by ADP in March 2015

- The initial assessment identified three cross-border product brands that have the potential for cost recovery, but further analysis is required. These are male condoms, third generation oral contraceptives and Sayana Press.
- The financial sustainability of PSI network members across the FP portfolio is still far off. The margins on most FP products are so low, if they even exist, that expecting continued and current levels of scale without subsidy will, in the view of ADP, be unrealistic.

This led onto Phase 2, where ADP did further analyses and came back to PSI with more evidence and refined recommendations and next steps. Three possible next steps from this are included below:

1. Improve cost accounting and cost controls to be more in line with business practices and models and less in line with the "NGO/project" approach to cost accounting.
2. Review structures – in an organization and region where some network members are very independent (e.g., GreenStar Pakistan or SMC Bangladesh) and some are still directly managed by PSI (e.g., PS/ Nepal), it is important to look at structures that impact on costs and the ability to undertake regional initiatives.
3. In 2016, explore product introduction with more of a regional perspective. These will be presented and discussed with USAID in the coming months as this evolves.

For this annual report, PSI's Asia regional team was surveyed on the impact ADP's analysis had on the business practices and FP objectives of PSI/Asia.

Staff unanimously reported that the assessment had resulted in an overhaul of expectations and business practices around costs. Independent PSI network members in Asia and those still reporting directly to PSI/Washington all took steps to better measure and manage their costs, with increases in revenue being the next step. One person feedback that, "the assessment highlighted the gap between the reality of being an organization dependent on subsidy, and the reality of how achieve health impact and serve PSI's mission, while increasing financial sustainability."

The other standout feedback from PSI regional staff was the enthusiasm and action the assessment created for new FP products and strengthening method choice in Asia, with particular interest generated in Sayana Press. Consequently, active planning has since been undertaken to develop the partnerships and dialogue for PSI network members in Asia to engage in discussions around introduction of Sayana Press in their respective markets.

This assessment also helped PSI network members to see beyond their national social marketing roots and to the wider total market at a national and regional level. An illustration that this is taking effect is the PSI network members in Asia committing to total market landscaping in FY 2016 (India and Cambodia) with others (Pakistan, Bangladesh and Nepal) seeking further capacity building to help them landscape and implement total market approaches.

1.2.13 Expand method choice through the introduction of a low-cost levonorgestrel intra-uterine system (LNG IUS) in Senegal

Anticipated Year One Outputs

- Product registered in Senegal
- Marketing plan developed

Year One Progress on Outputs

With technical support from PSI, ADEMAS is building upon the SIFPO2-supported FP market analysis in Senegal to develop a marketing plan for the LNG IUS. PSI will coordinate with MOH and other partners to develop a marketing plan based on PSI's TMA, which explores how diverse market players can coordinate to meet the needs of different segments of the Senegalese population.

Following delays in the negotiation of a central supply agreement, PSI and M360 have agreed to first sign an Agency Agreement that will allow M360 to share registration dossiers needed to begin the registration process. The agreement will be finalized in Q1 of FY 2016 after which time ADEMAS will apply its significant experience with ethical product registration and the regulatory processes in Senegal to finalize the dossier for submission. Negotiations will continue on the global supply agreement while registration is pending.

Result 2 Increased sustainability of country level FP and other health programs

Sub-Result 2.1 Financing mechanisms that improve sustainability of FP and other health services implemented or leveraged

Summary of activities and outputs

2.1.1 Develop a framework for assessing current financing and creating financial sustainability strategies for PSI Network Members, focusing on those with Social Franchise networks

Anticipated Year One Output

- A framework that can be applied to multiple settings by PSI Network Members to analyze sustainable FP financing options within their countries

Year One Progress on Outputs

- **Document and informant review**: R4D worked to understand PSI's needs and systems to better focus these activities. R4D gathered and reviewed documents to understand social franchising at PSI as well as to analyze the health market context and the health financing landscape of PSI's country networks. The R4D team also researched key USAID projects as well as global policy initiatives like FP2020 to better distinguish SIFPO2 plans and speak to ongoing work.

- **Partner consultation**: R4D also sought the opinion of PSI managers and R4D experts around financial sustainability. In addition, R4D organized formal consultations with PSI as well as partner organizations such as PharmAccess and MSI to better frame deliverables in the context of the landscape of health insurance and accreditation schemes. For instance, in February 2015, R4D organized a half day "Family Planning Health Financing" group meeting with PSI and PharmAccess so partners could share updates, review research, and provide feedback on deliverable and research plans.

This document review and consultation exercise helped to understand how PSI service delivery managers view financial sustainability and health financing's impact on the global goals of social franchising, such as promoting equity and expanding the market for FP services. It also led to a consensus that PSI network members stand to benefit from critically reviewing their financing mix and receiving tailored advice around the possibility and impact of increasing domestic revenue streams.

The R4D team then progressed to country selection and drafting the framework for health financing. A copy of this health financing framework is available upon request.

2.1.2 Pilot framework for sustainable FP financing prospects in two PSI/PRH countries

Anticipated Year One Outputs

- Framework piloted in two countries with corresponding reports focused on identifying sustainable domestic health financing opportunities and recommendations for PSI SF networks.

Year One Progress on Outputs

Country selection and finalization: R4D and PSI carried out a country selection exercise to narrow down the choice of cases for the first year. PSI & R4D reviewed key features for a set of 13 PRH priority

countries in Africa and Asia where PSI network members have FP programs. Information was gathered about key FP indicators, FP2020 commitments, government SRH policies, donor financing levels and future plans, presence of national or social health insurance schemes and the status of FP within them, and parallel USAID or other projects. In addition, working with PSI to gauge the interest and availability of platform managers was also an important consideration for the final choice. To this end, R4D developed a short "pitch" for the exercise, a working draft of its framework for health financing options analysis, and more tailored scopes of work for the country networks.

This exercise yielded positive results. PSI network members in Tanzania and Uganda came on board for health financing options analyses in Year One. PSI also received confirmation from SFH, PSI's independent network member in Nigeria, for similar work in Year Two. USAID concurrences for R4D work with these network members were also readily obtained.

Methods and outputs

The R4D team and a representative from PSI traveled to Dar es Salaam in May 2015 to work with PSI/Tanzania and to Kampala in September 2015 to assist PACE Uganda. Working closely with PSI network member teams, R4D implemented a framework for analyzing health financing options and producing actionable strategies for the country platform to grow and sustain the social franchise, focusing on FP as a core offering of the franchise. The framework organized each country analysis into an assessment of platform needs, landscaping of health financing sources and mechanisms, and analysis of the context of the wider health market. The process yielded tailored roadmaps of immediate, medium, and long term options for enhancing the financial sustainability of the social franchises in the two countries. In addition R4D's multi-step, collaborative process of assistance included:

- A health financing orientation for all relevant and interested platform staff at the beginning of the in-country work to ensure that all staff are acquainted with the terminology and empowered to engage in ideation around health financing;
- An assessment of the trade-offs between level of effort, timeframe, and potential impact on the global goals of social franchising for each identified option;
- A roadmap of the next steps and core competencies implicated in each option to strongly position the platform to meet their goals; and
- Submission of detailed notes of meetings with interview respondents as well as essential documents and resources that informed the exercise.

R4D followed up on the in-country work by producing detailed reports and slide decks for the PSI country and HQ teams. It also updated and submitted the overarching framework for health financing options analysis in order to continue developing an approach to financial sustainability at PSI. These deliverables helped make R4D's work easily consumable for PSI/Washington and country platform audiences to facilitate uptake and follow-up.

In Year Two of SIFPO2, in addition to working with new country teams and disseminating overall findings and methods, R4D will aim to support country teams in Tanzania and Uganda with further developing and implementing the most feasible and impactful options from Year One.

2.1.3 Pilot a social franchise profitability modeling tool

Anticipated Year One Outputs

- A finalized profitability tool with a report from at least one country's effort to apply this tool

Year One Progress on Outputs (October 2014 to March 2015)

PSI/Tanzania piloted a social franchise profitability tool during this reporting period. The tool was designed to help PSI/Tanzania and franchisees understand the profit generated by PSI SF products and services. In other words, the tool quantifies the financial value that the franchisor (PSI) adds to franchisee (the provider or clinic owner).

This tool helped PSI improve its understanding of costs and revenue (existing or potential) for PSI as the franchisor and for the franchisees, and was also designed to help franchisees improve their financial management and decision making.

The tool was applied by PSI/Tanzania to two urban, mid-sized clinics in October 2014. Both clinics are active franchisees in the *Familia* network. In one clinic, profit for LARC methods per quarter was only approximately US$13. However, cervical cancer screening or treatment, which are also supported by the *Familia* franchise, generated nearly $500 of profit per quarter for a clinic. For products, emergency contraception generated significant profit for a clinic, whereas oral and injectable contraceptives generated less than $25 profit in the most recent quarter.

Presenting this finding here is not to say one product or service is better than the other, nor is it breaking news that voluntary FP alone is sometimes not a lucrative business. In addition, the findings may be specific to Tanzania. However, the findings do illustrate for PSI that one PSI intervention can support the other. This has helped inform the strategic decision by PSI to increase Integrated Service Delivery in social franchising.

Some immediate decisions have been made based on the analysis in Tanzania. For example, the findings were used to inform the SIFPO2 Year One work plan activity to strengthen two social franchises with a focus on sustainability (Activity 2.1.5).

One example to illustrate this is that gathering the data from providers about their costs, revenue and profits was a challenging exercise and very labor intensive for the two PSI staff that did this. The difficulties in data collection are sometimes because of poor book-keeping by providers or because of the multitude of complex book-keeping processes required by government.

Whatever the reasons, the experience of piloting this tool Tanzania suggested the tool in its current form would be a difficult model to sustain in the long term. Therefore, one resulting action was the development of a tender for electronic records management (ERM) systems (including financial records) for providers in the Tunza franchise. This is still in its early stages, and there are pitfalls to such a project implementing electronic record keeping in an efficient and effective manner (not least, some of those already identified above), but there is consensus in PSI's East Africa regional team that there is value in exploring the possibility of an ERM for PSI Social Franchises in that region.

PSI/Mali

At the Social Franchise for Health conference in Philippines in October 2014, PSI social franchise leaders agreed to all better understand the value proposition, costs, revenue and financial sustainability of their business model. As a contribution to this, the profitability tool from PSI/Tanzania was translated into French and shared with PSI/Mali to undertake the same exercise, and build on lessons learned in Tanzania. Similar to PSI/Tanzania, PSI/Mali is reviewing its franchise business model so as to enhance performance against key indicators including impact, quality, equity, cost effectiveness, all while increasing the financial sustainability of the model.

Initially, in Q2 of this reporting period, a workshop session was carried out in Bamako, Mali, with a selection of providers to explain what PSI/Mali expects from this exercise and discuss with providers the records required for the profitability analysis. As a result, several reports have been compiled, such as:

- The list of services/benefits and price,
- The list of products sold and their price,
- The operational costs of the clinic (estimates), and
- The daily revenues and expenses of the clinic.

In contrast to PSI/Tanzania, which focused on costing and evaluating just the franchised services, PSI/Mali seeks to do the analysis for *all* of a franchisees' clinical services, so as to enable analysis of how the franchise sits within the broader context. This will add to the richness of the data, but does also increase the quantity of data required. Like PSI/Tanzania, PSI/Mali has also found that providers do not

always control or know well their costs associated with their different tasks, and this requires a lot of estimation that potentially weakens the validity of the cost data. However, even these estimations can often prove illuminating.

To date the exercise is proving useful to help PSI/Mali and franchisees better understand and control costs and revenue. This can then lead to improved value for all parties. During Year Two, PSI Mali will generate a final analysis of the results, adapt the tool to account for all clinical services and estimate the cost/revenue of the franchises services.

2.1.4 Develop and pilot a franchisor costing tool

Anticipated Year One Outputs

- A costing tool in a user-friendly template and with guidelines that will enable a country level franchisor to calculate costs using this template.
- A report from at least 1 country efforts to apply this tool

Year One Progress on Outputs

During the Social Franchising for Health conference in Philippines in October 2014, PSI presented to its social franchises the cost accounting tool developed in collaboration with MSI, and other members of the global Social Franchise Metrics working group, designed so that there was an industry standard for calculating and reporting cost-effectiveness.

However, the nature of such a broad collaboration as the SF Metrics Working Group means that tool needed adaptation by each organization so as to be accurate and of maximum value. Therefore, PSI convened a meeting in October 2014 of senior staff to address how to take forward a global review of cost accounting in PSI, and issued a tender to seek expertise to manage this process. That tender sought proposals responding to the following request:

1. **Undertake a cost accounting systems (CAS) assessment**

The objective of the CAS assessment is to assess the current state of the CAS used for tracking inventory and programmatic costs. The assessment would identify opportunities for improvement across the systems, people/organization capabilities and processes spectrum and result in a strategy for PSI to pursue and deploy these improvements.

2. **Undertake an Activity Based Costing (ABC) Pilot**

In a USAID PRH priority country, an ABC pilot will be planned and run with the objective to determine the viability of deploying an ABC process/system across the PSI international network.

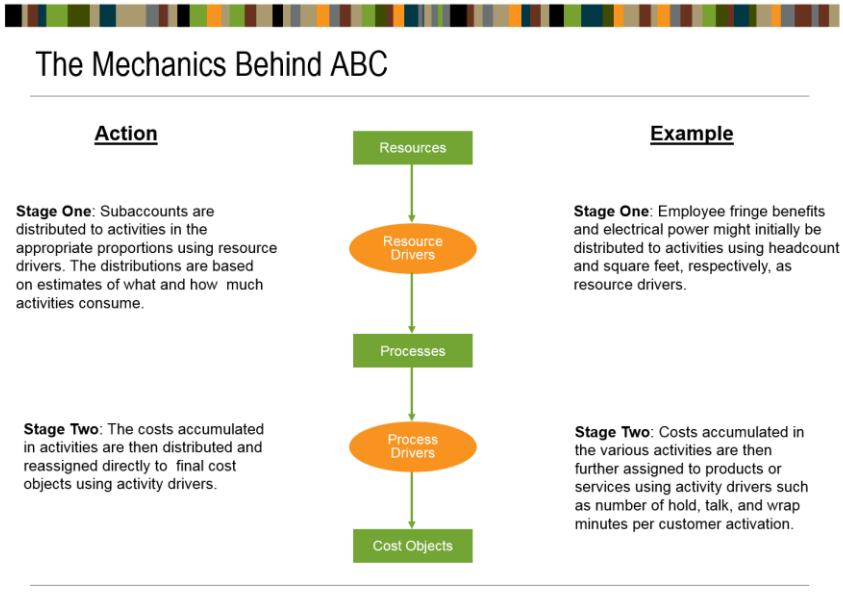
From April to September of 2015, PSI subsequently launched a partnership with US-based McGladry Consulting to deliver this above. PSI/Tanzania was selected as the pilot context that would imbed the draft approach and inform future goals and objectives.

All this work was done with attention to detail, measuring and allocating true costs (as opposed to cost analyses done by some organizations for external consumption) and with a view to creating sustainable systems that support the goal of greater financial sustainability. The results of parts 1 and 2 would allow PSI to then consider replicability of the system and processes and to determine the resources required to roll this out on a larger scale.

The pilot project in Tanzania has been very successful so far and staff are seeing for the first time costs for every service and product that they deliver. In the long-term, PSI expects to be able to provide data both internally and externally that can answer various questions regarding cost per health impact delivered, or value for money and numerous other questions that are difficult to answer today. Further information is available upon request as the information available runs to hundreds of pages of analysis and recommendations. However, for illustrative purposes and to provide a flavor of the work and the output, three of the slides from the work in Tanzania are included below. Using its own funds PSI is now undertaking the same exercise with PSI/India.

PSI will continue to report against this cost accounting exercise in SIFPO2 as it is fundamental to the goals of increased financial sustainability of SIFPO2.

Below are some key slides illustrating the process and outputs of the cost accounting pilot project.

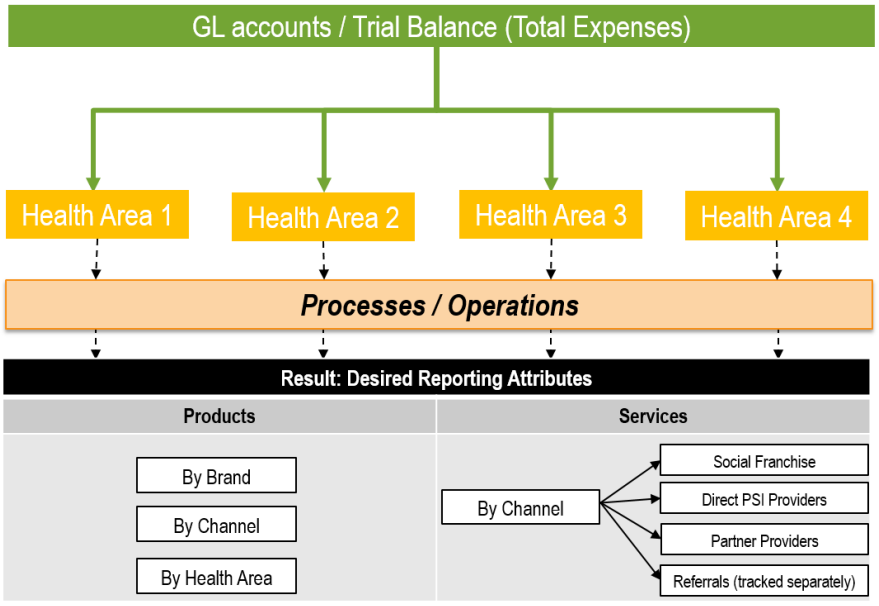


What We Costed in Tanzania

Product/Channel	Channel	Health Area	Description
FMCG			
024-EC-FG-CARTON-01	FMCG	Family Planning	P2 EC CARTON (80)
024-FCON-FG-CRTN-01	FMCG	HIV	CARE PACKED CONDOMS (180 PCS)
024-IMP-FG-CARTON-03	FMCG	Family Planning	IMPLANON (64)
024-IMP-FG-DISPENSER-01	FMCG	Family Planning	JADELLE IMPLANT DISPENSER (10)
024-INJ-FG-CARTON-02	FMCG	Family Planning	FAMILIA INJECTION CARTON (40)
024-IUD-FG-CARTON-01	FMCG	Family Planning	IUCD PREGNA - 20 PIECES
024-IUD-RG-EACH-01	FMCG	Family Planning	IUCD PREGNA UNPACKED
024-MCON-FG-CRTN-06	FMCG	HIV	SALAMA STUDS PACKED (432PCS)
024-MCON-FG-CRTN-08	FMCG	HIV	SALAMA BOMBA PACKED (432PCS)
024-MCON-RG-BOMBA-01	FMCG	HIV	SALAMA CHOCOLATE UNPACKED (BOM
024-MCON-RG-BOMBA-02	FMCG	HIV	SALAMA BANNANA UNPACKED (BOMBA
024-MCON-RG-BOMBA-03	FMCG	HIV	SALAMA STRAWBERRY UNPACKED (BO
024-MISO-FG-PACK-02	FMCG	Family Planning	MISOPROSTOL PACK (28 TABLETS)
024-OC-FG-DISP-01	FMCG	Family Planning	FAMILIA CONTRACEPTIVES PACKED
024-RH-FG-RDK-01	FMCG	Malaria	MALARIA RAPID DIAGNOSTIC KIT
024-TMARC-FCON-FG-CRTN-01	FMCG	Others/None	LADY PEPETA PACKED CONDOM (180
024-TMARC-MCON-FG-CRTN-01	FMCG	Others/None	DUME PACKED MALE CONDOM (432)
024-TMARC-MCON-FG-CRTN-02	FMCG	Others/None	DUME PKD MALE CONDOM 2'S (432)
024-TMARC-OC-FG-CRTN-04	FMCG	Others/None	FLEXI P PACKED (OC144) COMBO 3
024-WATER-D-FG-CARTON-04	FMCG	Water	WATERG TABS (7200PC) DNR PLWHA
024-WATER-D-FG-EACH-02	FMCG	Water	WATERG LIQD (150ML) DNR PLWHA
024-WATER-E-FG-CARTON-01	FMCG	Water	WATERG TABS (2400PC) ENF
Institution			
024-EC-FG-CARTON-01	Institution	Family Planning	P2 EC CARTON (80)
024-FCON-FG-CRTN-01	Institution	HIV	CARE PACKED CONDOMS (180 PCS)
024-IMP-FG-DISPENSER-01	Institution	Family Planning	JADELLE IMPLANT DISPENSER (10)
024-IUD-FG-CARTON-01	Institution	Family Planning	IUCD PREGNA - 20 PIECES
024-MCON-FG-CRTN-06	Institution	HIV	SALAMA STUDS PACKED (432PCS)
024-MCON-FG-CRTN-07	Institution	HIV	SALAMA HALISI PACKED (432PCS)
024-MCON-FG-CRTN-08	Institution	HIV	SALAMA BOMBA PACKED (432PCS)
024-MCON-RG-BOMBA-01	Institution	HIV	SALAMA CHOCOLATE UNPACKED (BOM
024-MCON-RG-BOMBA-02	Institution	HIV	SALAMA BANNANA UNPACKED (BOMBA
024-MCON-RG-BOMBA-03	Institution	HIV	SALAMA STRAWBERRY UNPACKED (BO
024-OC-FG-DISP-01	Institution	Family Planning	FAMILIA CONTRACEPTIVES PACKED
024-RH-FG-RDK-01	Institution	Malaria	MALARIA RAPID DIAGNOSTIC KIT
024-TMARC-FCON-FG-CRTN-01	Institution	Others/None	LADY PEPETA PACKED CONDOM (180
024-TMARC-MCON-FG-CRTN-01	Institution	Others/None	DUME PACKED MALE CONDOM (432)
024-TMARC-OC-FG-CRTN-04	Institution	Others/None	FLEXI P PACKED (OC144) COMBO 3
024-WATER-FG-SACHET-01	Institution	Water	PUR WATER TREATMENT POWDER

Product/Channel	Channel	Health Area	Description
PHARMACY			
024-EC-FG-CARTON-01	PHARMAC	Family Planning	P2 EC CARTON (80)
024-FCON-FG-CRTN-01	PHARMAC	HIV	CARE PACKED CONDOMS (180 PCS)
024-FCON-RG-EACH-01	PHARMAC	HIV	CARE UNPACKED CONDOMS
024-HIV-FG-LUB-01	PHARMAC	HIV	SHOSTI LUBRICANT - 5ML SACHET
024-IMP-FG-CARTON-03	PHARMAC	Family Planning	IMPLANON (64)
024-IMP-FG-DISPENSER-01	PHARMAC	Family Planning	JADELLE IMPLANT DISPENSER (10)
024-INJ-FG-CARTON-02	PHARMAC	Family Planning	FAMILIA INJECTION CARTON (40)
024-INJ-RG-VIAL-01	PHARMAC	Family Planning	INJECTABLE CONTRACEPTIVE
024-IUD-FG-CARTON-01	PHARMAC	Family Planning	IUCD PREGNA - 20 PIECES
024-IUD-RG-EACH-01	PHARMAC	Family Planning	IUCD PREGNA UNPACKED
024-MCON-FG-CRTN-06	PHARMAC	HIV	SALAMA STUDS PACKED (432PCS)
024-MCON-FG-CRTN-07	PHARMAC	HIV	SALAMA HALISI PACKED (432PCS)
024-MCON-FG-CRTN-08	PHARMAC	HIV	SALAMA BOMBA PACKED (432PCS)
024-MCON-RG-BOMBA-01	PHARMAC	HIV	SALAMA CHOCOLATE UNPACKED (BOM
024-MCON-RG-BOMBA-02	PHARMAC	HIV	SALAMA BANNANA UNPACKED (BOMBA
024-MCON-RG-BOMBA-03	PHARMAC	HIV	SALAMA STRAWBERRY UNPACKED (BO
024-MCON-RG-FAMILIA-01	PHARMAC	HIV	FAMILIA UNPACKED CONDOMS
024-MISO-FG-PACK-02	PHARMAC	Family Planning	MISOPROSTOL PACK (28 TABLETS)
024-OC-FG-DISP-01	PHARMAC	Family Planning	FAMILIA CONTRACEPTIVES PACKED
024-OC-RG-EACH-01	PHARMAC	Family Planning	FAMILIA CONTRACEPTIVES UNPACKE
024-RH-FG-RDK-01	PHARMAC	Malaria	MALARIA RAPID DIAGNOSTIC KIT
024-TMARC-FCON-FG-CRTN-01	PHARMAC	Others/None	LADY PEPETA PACKED CONDOM (180
024-TMARC-MCON-FG-CRTN-01	PHARMAC	Others/None	DUME PACKED MALE CONDOM (432)
024-TMARC-OC-FG-CRTN-04	PHARMAC	Others/None	FLEXI P PACKED (OC144) COMBO 3
024-WATER-D-FG-CARTON-04	PHARMAC	Water	WATERG TABS (7200PC) DNR PLWHA
024-WATER-E-FG-CARTON-01	PHARMAC	Water	WATERG TABS (2400PC) ENF
024-WATER-FG-SACHET-01	PHARMAC	Water	PUR WATER TREATMENT POWDER
HIV Testing	Services		Services
CCS testing	Services		Services

High Level Cost Model Design for Tanzania



2.1.5 Strengthen two social franchises with a focus on sustainability.

Anticipated Year One Outputs

- A sustainability strategy report, including recommendations, and improvement work

Year One Progress on Outputs

PSI took the challenges and opportunities raised during the October 2014 SF for Health Conference, and focused attention on the PSI's *Tunza* network in East Africa to address financial sustainability. The early steps in this activity were described as a success story in the SIFPO2 semi-annual report because this is a new direction for PSI and social franchising. During the second half of the year, PSI took further steps to improve and plan for implementation of this new business model.

As described in the semi-annual report, PSI is moving the *Tunza* social franchise towards a social business model in Kenya, Tanzania, Uganda, and Malawi. The model identifies how to increase operational efficiencies and better targets subsidies along a sustainability continuum for the franchise.

Improved Business Systems:

Support from SIFPO2 allowed PSI to contract Open Capital Advisors to develop the *Tunza* business model and test market the following *Tunza* value proposition in Kenya, Tanzania, Uganda, and Malawi.

The test market in the four countries shows that the *Tunza* franchisees' greatest expressed needs are: 1) medical & business training, 2) access to financing for business expansion, 3) clinic management systems, and 4) affordable quality drugs.

Nearly three quarters of the franchisees are willing to pay an average of $200 in franchise fees and 10 – 15% incremental revenue share for the value proposition. These fees and revenue share will be the main revenue streams that will move *Tunza* towards decreasing and better-targeted subsidies. Thanks to support from SIFPO2, PSI is in the process of doing a business analysis on pooled procurement options to increase the access to quality essential drugs and FP products as part of the overall value proposition and potential revenue stream.

PSI has moved forward on identifying the Clinic Management System (CMS) that will improve client flow & records, inventory management, revenues, and linked to DHIS 2 to provide management dashboards. The CMS is now the core equity share and requirement to be a *Tunza* franchisee. The system will cost $3,000 - $5,000 depending on the size of the Franchisee's clinic and client flow. The test market implemented by Open Capital Advisors showed that over 65% of the current franchisees are willing to invest in the CMS if there was financing available.

Increased Client Flow:

PSI is working with the countries in team to link them to third-party payer systems that will ultimately address some of the equity issues as well as increase the client base. A marketing strategy is being developed by PSI's regional marketing manager to develop segmented marketing plans for the franchisees and consumers.

So far, what are the outcomes and synergies that these activities have created?

- *Tunza* Kenya continues to be the incubator of the *Tunza* Business Model sharing experiences with the teams in Tanzania, Uganda, Malawi and wider PSI. The SIFPO2 sponsored Social Franchise meeting in May 2015 gave the country teams to share and learn about experiences transitioning to the *Tunza* Business Model. Each of the teams then took the learnings and adapted them to their franchise and markets.

- One common challenge for all the country programs is around adapting the current FP quality assurance and improvement tools and framework and applying the methodology and principles across the primary health care continuum for integrated health services. PSI/Washington staff are working on adapting the framework and tools and will provide support to the teams during Year Two.

- The SIFPO2 funding helps demonstrate cost share in country program's fundraising for the *Tunza* Business Model, attracting other donors to support this work. For example, PACE Uganda is working with Merck for Mothers (M4M) to fund a yearlong transition of their Profam Franchise to a *Tunza* Social Enterprise. PSI/Tanzania has presented a proposal to CIDA (Canada) to support a longer term transition to financial sustainability.

PSI will continue to report back on this business model as it evolves, and is constantly monitoring the trade-offs and opportunities that exist in this model for FP sustainability and for equity and access. PSI does not plan to develop a model that will exclude poorer populations at the expense of people with greater ability to pay. That is not the purpose of this new model.

2.1.6 Identify barriers to access to credit for franchisees and develop a strategy to overcome these barriers

Anticipated Year One Outputs

- Strategy developed to improve access to credit for small and medium healthcare enterprises, including franchisees in PSI's global network.

Year One Progress on Outputs

This activity was initially designed for PSI to work with PharmAccess Group's Medical Credit Fund to develop a strategy to improve access to credit. However, PSI's plans for this activity evolved after a January 2015 study tour when PharmAccess and PS Kenya hosted three PSI programs from East Africa and members of PSI/Washington to better understand the SafeCare QI methodology within PSI/Kenya's Tunza social franchise clinic operations.

Following the visit, PSI and PharmAccess decided to focus energies in SIFPO2 Year One on the SafeCare certification scheme, particularly on determining how to integrate existing (internal) QA programs with a broader (external) QI and recognition program that encompasses all services delivered.

A further reason for not taking this conversation on "access to credit" further forward between PSI and PharmAccess in Year One is that under Activity 2.1.5, Open Capital and PSI East Africa have done extensive assessment and planning to increase access to credit for franchisees. Local credit markets have evolved so rapidly and to such an extent in East Africa that whereas a few years ago, PharmAccess and their access to credit and link to quality may have been pioneering in East Africa, there are now a lot more players and opportunities in that space in terms of access to credit for providers. PSI is actively exploring those partnerships for its social franchise networks in East Africa.

2.1.7 Coordinate and contribute to quarterly Health Finance Working Group meetings and provide technical and practical expertise to partners

Anticipated Year One Outputs

• Quarterly meetings held

Year One Progress on Outputs

As described in previous activities (e.g., 2.1.1) PSI is coordinating numerous meetings to create consensus on health financing and SIFPO2 among key stakeholders. A meeting of MSI, PSI and R4D was convened in Q1, during which MSI shared their experiences and tools for health financing assessments under SIFPO1 and PSI shared its plans with R4D for SIFPO2. PSI and MSI ensured that our priorities were incorporated into the Joint Learning Network coordinated by R4D, which designed financing mechanisms for universal health care.

A meeting was held in February 2015 between PSI, Pharm Access and R4D staff to take the subject matters forward. For example, R4D sent PharmAccess information on R4D's work under Health Finance and Governance project. PSI shared information on social franchising in India with PharmAccess. PharmAccess were to share updates on or medium term strategy for SafeCare with partners such as PSI so they can be well positioned to support it, particularly in key regions like East Africa.

No further meetings were held in the second half of the year because both partners, R4D and PharmAccess, were busy implementing the measures that would be ripe for discussion. For example, R4D were busy in May and September undertaking the financing assessments in Tanzania and Uganda. PharmAccess were negotiating with PSI on the launch of the pilot in Uganda. During Year Two, when these efforts have begun to take root and showing signs of results, PSI will convene a coming together of partners to discuss health financing again and its links to quality FP delivered via social franchising.

Sub-Result 2.2 Capacity of local partners to provide quality FP and other health services built

Summary of activities and outputs

2.2.1 Conduct a desk review of various Quality Accreditation approaches

Anticipated Year One Outputs

- Desk review conducted

Year One Progress on Outputs

PSI conducted a landscape analysis of certification and accreditation mechanisms and bodies, outlining key components of each, and summarizing advantages, challenges and special considerations for developing country settings. The review found that accreditation programs were largely applicable to larger, more sophisticated facilities than PSI's network members, and few certification programs were adapted to developing country settings. One exception is the SafeCare model, which is currently being piloted by PSI in East Africa. Limitations of this model include a narrow geographic scope, cost, and scalability. PSI will use the results of this assessment to see how PSI programs can best utilize external certification programs to improve clinic-level performance while balancing cost and resource constraints.

2.2.2 Continue the support of regional QA leads

Anticipated Year One Outputs

- Identify at least one regional QA lead
- Design a plan for rolling out a program that will provide on-going support and mentorship to PSI's regional QA leads

Year One Progress on Outputs

PSI identified three local PSI QA Managers to act as QA Regional Leads for the East Africa, Southern Africa and Francophone Africa regions. SIFPO2 now supports 15% level of effort for 3 PSI network member staff from PACE Uganda, PSI/Zimbabwe and PSI/Madagascar to lead a variety of QA initiatives for their respective regions. QA Regional Leads conduct at least one external QA audit in another PSI FP program each year; review all external QA audit reports for PSI FP programs in the region and provide support to programs designing action plans that respond to audit findings; support PSI's efforts to roll-out a CME program; and provide distance adverse event management support. With an eye towards sustainability, QA Regional Leads will take on an increasing level of responsibility as they become the first point of contact for FP/RH QA needs in their regions.

2.2.3 Conduct a TOT for clinical supportive supervision

Anticipated Year One Outputs

- Clinical supportive supervision TOT held for staff in one region

Year One Progress on Outputs

In January 2015, a PSI SRH technical advisor conducted a one-day training in Kampala for 12 regional supervisors (i.e., supervisors of supervisors) from PSI's Ugandan affiliate, PACE, utilizing a curriculum and guide developed under SIFPO1. The curriculum was developed based on external QA audits observations and input from PSI QI teams based in the field.

The training included strategic preparation for supervisory visits to maximize results, documentation to allow for continuity between supervisory visits, and hands-on exercises to improve supervisor communications skills and provide actionable feedback. Whereas PSI QI trainings have often focused on technical skills and the interaction between supervisors and network providers, the new curriculum also incorporates guidance for managing *supervisor* performance.

PSI also included the new curriculum during its training of QA Regional Leads, described in the following section.

Based on the Kampala and QA Regional Lead trainings, PSI has adapted the curriculum to incorporate lessons and training techniques from PSI's provider behavior change communication work. In September 2015, PSI's Global Medical Advisor and a Provider Behavior Change Associate leveraged a training funded by another donor to test the new curriculum.

2.2.4 Host a workshop to support PSI's regional QA leads

Anticipated Year One Outputs

- Needs assessment prior to workshop conducted
- Agenda and curriculum developed
- Workshop held
- Action plans developed for each QA lead

Year One Progress on Outputs

In February, 2015, PSI led a workshop to roll-out the QA Regional Lead program. The main objectives of the workshop were to provide QA Regional Leads with clear expectations for successfully fulfilling their roles as QA Regional Leads, and the skills to do so. During the two-day workshop, PSI's Global Medical Director, Global Clinical Advisor, SIFPO1 Deputy Director and SIFPO1/2 Technical Advisor led sessions around leading QA audits and giving feedback to PSI QA Managers; clinical coaching role play; guiding programs through the implementation of an adverse event drill; supporting programs to adhere to the principles of informed choice; and QA needs related to integrated service delivery. SIFPO2 supported participants from Zimbabwe, Madagascar and Uganda; PSI's Women's Health Project supported the participation of QA Regional Leads from India, Pakistan and El Salvador. After the workshop, each QA Regional Lead developed goals for the following year including identifying countries where they will lead external QA audits, trainings they will co-facilitate and QA audit follow-support they will provide to countries in their respective regions.

2.2.5 Conduct a regional Youth Friendly Health Services (YFHS) Training of trainers (TOT)

Anticipated Year One Outputs

- One regional YFHS TOT conducted

Year One Progress on Outputs

This activity is included as a success story at the beginning of this report. In summary:

PSI's first regional training of trainers for youth-friendly health services was supported through SIFPO2. The training was held September 7-11, 2015 in Harare Zimbabwe. With cost share from other projects, SIFPO2 brought together 16 participants from 11 countries - Angola, Burundi, Ethiopia, Kenya, Nigeria, Malawi, Mozambique, Tanzania, Uganda, Zambia, Zimbabwe – for five days of participatory learning and skills-practice to create an army of amazing facilitators. One participant came from a partner organization, ChildFund/Zambia, and the remaining 15 were PSI network member staff. The training focused on experiential learning and practice. Participants were able to both experience the youth-friendly health services training by undergoing all of the activities in the curriculum, as well as practice and learn how to facilitate the activities found in the curriculum. In addition, they learned basic facilitation skills, how to plan for a YFHS training, and how to engage young people in the training.

A Francophone Africa regional training of trainers is planned for Year Two of SIFPO2.

2.2.6 Organize a technical consultation on Adolescent and Youth Sexual and Reproductive Health (AYSRH)

Anticipated Year One Outputs

- Workshop held and new technical guidance on AYSRH implementation distributed to PSI programs and partners

Year One Progress on Outputs

On September 29, 2015, PSI and IPPF hosted "Tools of Engagement: Exchanging knowledge and ideas for meaningful youth engagement in sexual and reproductive health programs," which brought together about 60 implementers, advocates and researchers from the SRH space to discuss youth engagement. The event consisted of seven brief talks that were delivered by a range of experts from both within, and outside, the health sector. In the afternoon, participants took part in two of four workshops on youth-centered design, organizational mainstreaming, youth-adult partnerships and measuring positive youth development. A multi-media report (consisting of videos, graphic recording, and key messages/recommendations) is available.

2.2.7 Provide technical assistance to network members to design, build, improve, and expand FP service delivery including through SF

Anticipated Year One Outputs

• Technical assistance provided to at least two countries

Year One Progress on Outputs

PSI Zimbabwe

An assessment of PSI/Zimbabwe's SF models in March 2014 was conducted in collaboration with the International Center for SF, cost-shared using PSI's own funds from PSI/Southern Africa region. This assessment realized a series of concrete recommendations for PSI/Zimbabwe to strengthen its approach to social franchise. SIFPO2 Director attended part of the assessment to learn and disseminate relevant findings to PSI/Washington staff and staff in USAID PRH priority countries. A sample of the recommendations included the need to review social franchise roles and responsibilities, value proposition, partner criteria and financial modeling. *ProFam* is an example of what can be defined as public sector SF. This is a model that was discussed at the SF for Health Conference in 2014 and seems to have potential as a means of working to support FP/SRH in the public sector. It is definitely a model to watch closely, learn, evaluate, and potentially disseminate and replicate.

In April 2015, SIFPO2 support enabled a PSI SRH technical advisor to provide RH/FP technical assistance during an "Immersion" workshop in Tanzania that was funded by a philanthropic partner and led by IDEO.org. Using Human Centered Design (HCD) techniques, the facilitators, in consultation with PSI/Tanzania, came up with the following design challenge to guide the Immersion: "How might we design a culturally relevant, measurable and sustainable program that gives young unmarried females age 15-19 in Bagamoyo, Tanzania greater decision-making power and encouragement to prevent unplanned pregnancy?"

The HCD process included:

1) **Insights:** Quick and brief qualitative research as well as a review of existing research and the Demographic Health Survey. This took place four months prior to the Immersion, led by a small IDEO.org team. The first day of the immersion week was also spent gathering insights.

2) **Immersion:** A workshop that included brainstorming, rapid prototyping and feedback labs with target audiences.
3) "**Live prototyping**" (one step before a pilot) of new program designs. This is the phase that will come next for PSI/Tanzania with funding from a philanthropic partner.

Six ideas were rapidly prototyped during the week. Highlights included:

1) Girl Nation Radio: a teen-focused radio storytelling that provides information about contraception and sexuality with captivating drama.

2) Girl-only, girl-driven transport: One big issue in Bagamoyo is teen girls having sex with motorcycle taxi drivers in order to pay school fees and get to school. For this prototype the group paid a driver to paint and brand his taxi; trained a local teen girl to learn how to drive it; and then went out seeking teen girls in need of transport.

3) Tech trade school for girls: In the back of a cell phone store, girls take technology repair classes as a way to earn income. The approach includes sexual health education plus referral for voluntary FP counseling and services.

PSI/Tanzania will now include in current and future program design some of the more promising ideas born out of this exercise.

2.2.8 Participate in the Global Conference on SF and facilitate sessions to improve the capacity and metrics of social franchise operations

Anticipated Year One Outputs

- Program meeting held for PSI network member staff
- Global Conference on SF attended

Year One Progress on Outputs

In October 2014, representatives from PSI SIFPO2 team traveled to Cebu, Philippines for the 2nd Global Conference on SF for Health and related events. While in Cebu, these staff focused efforts on four objectives:

Objective #1: Co-facilitate metrics sessions at PSI's pre-conference meeting

On October 20 and 21, 2014, PSI hosted a pre-conference meeting for PSI delegates. The objectives of the pre-conference sessions were to:

- Improve the collection and use of SF metrics;
- Create movement on defining and planning a new SF business model; and
- Improve compliance with SF minimum standards.

This meeting was about learning, but also information gathering. The meeting revealed, for example, that nearly all PSI Social Franchises are in a position to report figures for health impact, both services and product sales/distribution through franchises. However, the following countries identified the need for support to conduct equity studies: Mali, Pakistan, Uganda, and Tanzania.

The overwhelming need identified was assistance on cost accounting for cost-effectiveness. This helped inform momentum for the PSI cost accounting work (Activity 2.1.4.)

Objective #2 Participate in invited sessions and attend 2nd Global Conference on SF for Health

PSI staff were invited to sessions sponsored by conference organizers on October 22, 2014. One session on quality for voluntary FP displayed that the majority of SF quality frameworks focused on structural quality and not process quality. Participants worked in small groups to prioritize areas for process quality and agreed that they should include infection prevention, providers' technical skills, providers' counseling skills, the client's experience, and provider safety. The group agreed to incorporate the feedback that participants provided to build off of the "Bruce-Jain" framework and inform a framework that includes a process quality component.

Another session focused on financial sustainability. Key takeaways from this session included:

- There is an increased focus on sustainability for SF – franchisors cannot assume that donor funding will always be there. However, the community still needs to define what sustainability means and how to measure it.
- There will likely still be a role for subsidy, but it needs to be better managed.
- Government and social health insurance funding can be a core source of support.
- The pursuit of sustainability may necessitate tradeoffs with mission goals for franchise organizations.

Major takeaways from the conference were: Social insurance can and will likely play a large role in financing services, including shifting resources to the poor so they can access needed services.

- SF should be repositioned and include the movement toward universal health coverage.

- Different funding mechanisms will be necessary to sustain social franchises, including cross-subsidization, public-private partnerships, financing schemes, and commercialization.
- SF can and should occupy a unique position between private and public health provision. Social franchisors will increasingly be called upon to play a coordination role for governments, including providing needed business skills to providers and supporting accreditation.

These takeaways have fundamentally informed the PSI Strategic Plan refresh of 2015 as well as the SIFPO2 work plan for Year One and Two. A further example of PSI's strengthened position on these issues post-Cebu is the joint PSI-MSI Op-ed on Universal Health Coverage day in December 2014.

2.2.9 Undertake a 'Needscope' analysis of the condom market in Madagascar to increase cost recovery, sustainability and health impact of condoms for voluntary FP

Anticipated Year One Outputs

- Condom analysis completed and informing future strategies

Year One Progress on Outputs

The contraceptive prevalence rate among married women in Madagascar increased 20 percentage points from 1997 to 2008. However, as of 2008, only 29% of married women were using a modern contraception method and 19% of married women continued to report an unmet need for FP.[1] Even as method choice expands, condoms remain the preferred FP method for many people.

Research led by the marketing agency TNS looked at the emotional needs driving behaviors in the condom market. This included understanding:

- Attitudes toward sex and condom usage;
- The nudge factors, social "buzz" around condoms, pressures and influences for and against use;
- Motivations for condom use;
- Anxieties regarding use;
- Beliefs, taboos, socio-cultural influences, and prejudices;
- Functional brand and product features and perceptions; and
- The barriers and needs of traders selling the condoms.

The focus on condoms resulted from evidence that the perceived effectiveness of condoms for FP has a direct bearing on whether condoms are used.[2] Since 2009, PSI/Madagascar has positioned its

[1] Madagascar Demographic Health Survey (2008). Antananarivo, Madagascar: INSTAT & ICF Macro.
[2] Ibid.

mainstream condom brand as a HIV prevention method rather than for FP. This was for valid reasons at the time however it is now recognized that FP and SRH issues should take precedence in condom marketing as the HIV burden in country is low. UNAIDS reported the HIV prevalence in Madagascar for 15-49 year olds to be 0.3% in 2014 while prevalence of STIs such as syphilis was 7.7% among women who attended antenatal care in 2009.

The study began in September 2015, and the final dissemination will place in December 2015. The study comprised of in-depth interviews with male and female consumers and traders in urban, peri-urban and rural settings.

The top line findings from the report show that the main reason people use condoms in Madagascar is pregnancy prevention because they are concerned about the financial costs of unintended pregnancy. This finding backs anecdotal evidence and PSI/Madagascar's hypothesis that stronger positioning of the condom brand as a FP product would allow people to take more control of their lives and would assist sales.

PSI/Madagascar's existing condom brand "Protector Plus"

There were some key gender differences in the findings. Men use condoms to prevent pregnancy with "unknown" girls (not their "regular" partners), are more likely to have several sexual partners than women, and are the primary purchasers of condoms. Women use, or are more likely to insist on using condoms, during certain points in their menstrual cycle. Many women often cannot afford to use condoms throughout the month hence economize by using the rhythm method and condoms in combination; this is especially true of older women who are in likely to be in relationships. They are likely to follow their partner's brand preference; men's brand preference depends on how much money they have.

[2.] Townsend, J.W. & Jacobstein, R. (2007). The changing position of IUDs in reproductive health services in developing countries: opportunities and challenges. Contraception. 75(6 Suppl):S35-40.
[3.] Meekers D, Silva M, Klein M, 2006. Determinants of condom use among youth in Madagascar.

Younger women are more skeptical of other contraceptive methods due to fears of health effects. The study found no religious stigma relating to condom use; however, there are a number of limiting social norms and attitudes, such as assumptions that condoms are not necessary to use when in a relationship, and that buying condoms is a social indicator for infidelity.

Urban dwellers expressed more comfort with openly purchasing condoms than rural dwellers but both groups indicated that discretion during a purchase is necessary. People of all ages generally avoid being openly seen to buy condoms so they are likely to:

- Purchase in a neighboring area, village or city to allow anonymity;
- Wait until they are the only customer;
- Ask a child to buy on their behalf; or
- "Borrow" condoms from a friend if you are male.

While health concerns regarding HIV/STI are a secondary reason to buy condoms, the market still showed a lack of understanding or education regarding STI prevention via condom use. The research identified three common myths about condoms:

- Perception that the use of condoms transmits viruses, rather than prevents them.
- Perception across consumers all ages and genders that Protector Plus condoms stimulate hair growth, hence the brand is bought for this specific use.
- Consistent mention by women that Protector Plus is a nourishing skin care treatment to boost skin elasticity, glow and healing. Again the brand is bought for this specific use.

While Protector Plus is seen by all respondents as a trustworthy and affordable brand concerns and opportunities about the product features were raised both by consumers and trade, with particular concern regarding poorer durability and unpleasant smell. There is also a market gap in terms of size variants as there are no small size condoms. The limit in terms of colors and scents was also highlighted. Interestingly, no condom on the market discussed sexual pleasure with protection in its marketing. All traders noted that further education of the benefits of using condoms is still a pertinent requirement to further promote use. They were also concerned about stockouts.

The headlines of the recommendations of the study include:

- Improve stock availability with wholesalers to grow availability and accessibility;
- Enable a distribution network to rural/ remote small traders;
- Have geographical price differentiation as consumer affordability varies in high-density versus rural areas;
- Allow higher profit margins for rural traders so that they carry the product more readily;

- Enable purchase discretion, especially for females (e.g., partner with other female care product companies);
- Boost brand visibility to drive condom education and use.

The study found that the "YES" condom brand recently launched by PSI/Madagascar addresses some of the issues identified (e.g., the packaging is not typical of condoms hence more discreet and there is more interest in the product by women in urban areas). However, there is no doubt that there is room to improve the marketing of condoms in Madagascar, specifically focusing on distribution, messaging and product attributes. The study has provided an opportunity to re-visit and re-invigorate condoms as an FP method in Madagascar, as well as an HIV prevention intervention.

Sub-Result 2.3 Innovative partnerships to strengthen service delivery networks pursued

Summary of activities and outputs

2.3.1 Identify and develop innovative partnerships

Anticipated Year One Outputs

- Innovative partnerships identified and pursued

Year One Progress on Outputs

This sub-result is relatively broad and overlaps with others. For these reasons, it is worth recapping the purpose of the activity from the original technical proposal.

SR #2.3: Innovative partnerships to strengthen service delivery networks pursued. PSI and partners will focus on the creation of partnerships that will:

1) Improve collaboration between the private for-profit, non-profit and public sectors,
2) Strengthen the provision of high-quality, cost-efficient FP services,
3) Integrate the provision of FP and other important health services.

For example:
- **Increase High-Impact Public/Private Partnerships**. Several public-private service delivery models are proving to be cost-effective for FP and other service provision.
- PSI will also explore the expansion of current **partnerships with pharmaceutical companies** to introduce cost recovery and mid-market products that can increase the cross-subsidization of lower priced products.

- **Integrate FP with Other Health Services.** Currently 55% of PSI's social franchises offer two or more services beyond FP. These services typically cover some combination of the following health areas: FP; malaria; water, sanitation, and hygiene; nutrition; HIV and AIDs; STI screening and treatment; tuberculosis; prenatal care; safe delivery; and/or post abortion care, among others. Under SIFPO2, PSI will further integrate services based on each country's burden of disease and an analysis of services that can be efficiently integrated and generate impact.

PSI works with public and private sectors, and the pharmaceutical sector, in many different countries and contexts so to elaborate on this in full would be lengthy and of limited value in terms of showing the additional results of the investments of SIFPO2 core funds. However, the following activities under this sub-result have all received the support and a level of effort from SIFPO2.

Integrate the provision of FP and other important health services.

This is an activity PSI has committed significant effort to as it is fundamental to the sustainability and strengthen impact of work, particularly in social franchising.

Integrated approaches to service delivery provider QA: Kenya, Tanzania and Nigeria

QA builds the foundation for a better health system and encourages clients to seek care. PSI is condensing and combining tools used to assess quality in areas such as site selection and infection prevention across all health areas. A full inventory of QA tools will be harmonized and streamlined by early 2016. PSI is also developing an integrated QA framework to help health departments identify continued integrated opportunities for financial and human resource efficiency gains. The framework will be available by early 2016 with country piloting starting later in the year. The Health Network Quality Improvement System, a tool supported with SIFPO2 funds, will be a key tool for streamlining.

Referrals and linkages: Swaziland, Uganda, Tanzania and Zimbabwe

In September 2015, PSI began working with fellows from Alere, a leader in rapid point-of-care diagnostics, to develop guidance on an effective framework to be piloted in Swaziland for referrals from HIV testing services into treatment and care. Swaziland was prioritized because of the interest in USAID in partnering with PSI in Swaziland for field support funding. PSI will develop case studies on HIV referral processes in Uganda, Tanzania and Zimbabwe, to help build out a more universal framework for use by the PSI network in 2016.

Expansion of services to support social franchising

PSI is developing a framework to integrate fever case management and cervical cancer screening offerings into our social franchise networks. By the end of 2015, a technical brief on current practices, barriers and lessons learned for integration of cervical cancer screening with both FP and HIV will be developed and disseminated.

Improved and increased standardization of social franchise metrics

With the support of PSI Program Analytics team and PSI's Strategic Research and Evaluation, the annual reporting process to the Social Franchise compendium was streamlined and data reporting requirements were harmonized across geographies. This small step has enormous ramifications in a global organization, but the dividend will be better quality and quantity of data.

Pharmaceutical/corporate partnerships

In addition to partnerships explained earlier in this report (e.g., Accenture Development Partners), PSI continues to pursue innovative partnerships, learn from others, and ultimately enhance country-level programming. The following highlights two such partnerships.

PSI has launched a ground-breaking philanthropic and advocacy initiative aimed at catalyzing the next wave of philanthropists setting out to improve the health and rights of girls and women worldwide. Co-chaired by Her Royal Highness Crown Princess Mette-Marit of Norway and Melinda Gates, PSI is driving strategic investments that go beyond the checkbook by engaging the time and talents of philanthropists who have more than just their funds to invest. Together with private philanthropists and partner organizations, PSI will implement potentially game-changing pilot projects, measure their effectiveness, and use the results to leverage additional funding from large government and foundation donors to bring successful projects to scale. In 2015, PSI received support from an individual donor to introduce Sayana Press through the private sector in Mozambique. PSI is in discussion with the USAID/Mozambique Mission about the possibility of a Sayana Press commodity donation to complement this philanthropic program funding.

Since 2003, Pfizer and PSI have partnered on Pfizer's Global Health Fellows (GHF) program. The Pfizer fellows have volunteered their expertise to various PSI country offices serving three- to six-month assignments centered on improving PSI's sales, marketing and supply chain operations.

In 2014, building on our long history of successful partnership, PSI hosted a new initiative born of the partnership between Pfizer and PSI. Twelve Pfizer senior executives volunteered their skills representing functions such as research and development, commercial operations and legal affairs. At Pfizer, these

colleagues are responsible for significant annual operations and oversee thousands of employees. This partnership helped to further educate Pfizer leaders on how the social sector delivers health products and services, and offered them insights into emerging markets. The Pfizer team visited PSI programs in Ethiopia and India. The team conducted site visits and in-depth meetings with local and national governments, donors, partner NGOs, and local private sector players. Through these experiences, team members developed their understanding of the role that NGOs and corporations play in global development. The partnership made a set of strategic recommendations to help PSI remain agile in the face of transformative changes in the development field. Ultimately, these recommendations will aid PSI in continuing to be at the forefront of bringing important health interventions to those that need them the most.

Field Support Investments

Under SIFPO2, PSI conducted activities with field support funding in Benin, DRC, Guatemala, and Malawi. During this reporting period, SIFPO2 work plans complemented SIFPO1 work plans in each of these countries**.** This report includes activities under SIFPO2 only.

Benin

The following highlights the achievements in Benin from October 1, 2014 – September 30, 2015 of the SIFPO2 project. Additional information, including information on Objective 1 can be found in the SIFPO1 annual report.

Result 1: Increased access to integrated FP services and products.

Under this result, PSI's network member in Benin, ABMS, focuses on increasing access to voluntary FP services and products through the distribution of *Laafia®* FP products and expansion of the *ProFam* social franchise network.

Key Activities:

The following key activities under Result 1 occurred in FY 2015:

- Packaging of *Combi 3* oral contraceptives and *Prudence Plus* condoms. Distribution costs were covered through SIFPO1 funds and sales were reported in the SIFPO1 annual report.

Result 2: Increased demand for integrated family planning services and products

Increasing Demand for Voluntary FP

For FY 2015, ABMS's primary activities to promote demand for voluntary FP services and products included mass media marketing campaigns throughout the year for ABMS products. The 2015 marketing plans for the *Laafia* umbrella brand of FP products, as well as *Prudence Plus*, *Aquatabs, Orasel Zinc* were completed in November 2014 and were executed through the year. These marketing plans guide the pricing, promotion, and placement of each product.

In FY 2015 ABMS expanded the third phase of the co-funded *Laafia* communications campaign. The first phase of the campaign focused on brand recognition, following the launch of the *Laafia* brand in 2012, while this phase focuses on promoting the advantages spacing births, planning for children and their

future and adopting modern FP methods not only for maternal health but also for family welfare. In addition to the promotion of *Laafia*, ABMS promoted *Prudence Plus* condoms and HIV testing services.

To encourage the prevention and treatment of diarrhea through the additional funding available under SIFPO2, ABMS executed a pharmacy and supermarket-based promotion of *Aquatabs* and *Orasel-Zinc* through 25 independent distributors in October, June, and July in Cotonou, Abomey-Calavi, Porto-Novo, and Parakou. This type of promotion seeks to raise people's awareness of the need to treat one's water with *Aquatabs* especially during the rainy season, as well as highlight where one can access these important health products. During this fiscal year, ABMS also aired radio spots, radio programs, and television spots on diarrheal disease issues, disseminated key messages through Facebook, and produced promotional materials (e.g., 20-liter demonstration stand, posters, stickers, and flyers).

Key Activities:

The following key activities under Result 2 occurred in FY 2015:

- Implementation and expansion of communications campaign to promote of the *Laafia* line of FP products focused on promoting the advantages spacing births, planning for children and their future and adopting modern FP methods not only for maternal health but also for family welfare;
- Promoted Prudence Plus condoms and HIV testing services through radio spots and Facebook;
- Aired radio spots, radio programs, television spots on diarrheal disease prevention and treatment, disseminated key messages through Facebook and produced promotional materials such as 20-liter water treatment demonstration stand, posters, stickers, and flyers;
- Executed a pharmacy and supermarket based promotions of *Aquatabs* and *Orasel-Zinc* to raise awareness of the importance of treating drinking water and to highlight where to buy the two products.

Results:

- *Laafia communications campaign***:** More than 32,897 radio spots and 5,152 announcements, 25 radio shows, 192 TV spots and 30 short TV shows aired;
- Promotion of *Prudence Plus*: Over 17,000 radio spots, 2 685 announcements, 38 radio shows, and 40 short TV shows aired; and
- Promotion of *Aquatabs* and *Orasel Zinc*: Over 13,100 radio spots, 2,642 announcements, 11 radio shows, 37 short TV shows, and 327 television spots aired.

***Pilot Communication Campaign* on the dangers of purchasing, using or selling substandard ACTs**

With funding from the President's Malaria Initiative, a pilot communication campaign was launched under SIFPO2 to inform mothers and guardians of under 5 children of the dangerous effects of fake artemisinin-based combination therapy (ACT) drugs, and where to acquire legitimate ACTs for the

treatment of malaria. Following the launch of the collaborative communications campaign by USAID, MOH, and ABMS to fight counterfeit and substandard ACTs in October 2014, ABMS continued the development of the campaign messages, recruitment and training of interpersonal communication (IPC) agents. ABMS leveraged its existing in-country expertise in community education and mass-media campaigns to educate family members responsible for purchasing anti-malarial medication, informing them of the dangers linked to counterfeit or substandard medication, such as the increased risk of morbidity and mortality, and encouraging them to purchase quality assured medication at certified distribution points. In addition, ABMS sought to educate small business entrepreneurs selling such medication, informing them of the illegal nature of the activity as well as the dangers such medication poses for their clientele, and encouraging them to cease selling substandard or counterfeit medication.

Key Activities:

- Official launch ceremony of the ACT campaign in the Dantokpa market, attended by the Minister of Health and the U.S. Ambassador;
- Development of a communications campaign targeting care takers of children under 5 and vendors in Dantokpa market on the dangers of purchasing, using or selling substandard ACT;
- Executed a workshop to validate key messages with the National Malaria Control Program (PNLP) on the dangers of purchasing, using or selling substandard ACTs; and
- Executed qualitative study on attitudes and behaviors associated with malaria treatment in Dantokpa market
- Recruitment and training of interpersonal communication agents to conduct education in Dantokpa markets on the dangers of purchasing, using or selling substandard ACTs.

Results:

- Contracts signed with 4 mass media outlets to broadcast 1,867 radio spots, 2,196 radio announcements, 6 radio programs, and 39 television spots on the dangers of purchasing, using or selling substandard ACTs;
- 1,709 sessions in 5 neighborhoods around Dantokpa conducted by 10 IPC agents on the dangers of purchasing, using or selling substandard ACTs;
- 98,000 people reached through promotions on Facebook, engaging over 6,800 in an on-going conversation on the dangers of purchasing, using or selling substandard ACTs;
- Of 1,976 calls on issues associated with malaria treatment were received on ABMS's toll free Hotline, 114 were about suspected substandard ACTs medicines.

Challenges

The launch ABMS's second awareness campaign targeting vendors in the market about the dangers of substandard and counterfeit ACTs was delayed until July 2015. The two factors that contributed to this

delay were:

- Increased security around elections in April and May, which limited the ability to do demonstration and mobile video sessions in Dantokpa market.
- Resignation of the Director of Dantokpa Market (SOGEMA), with whom USAID and ABMS had been working to launch the campaign, and replacement by a less supportive director.

Ebola Virus Disease (EVD)

An EVD-focused work plan for Benin was approved in August 2015. Activities will support: "Increased knowledge and understanding of EVD among the general public, including prevention and risk reduction, notification and treatment of suspected cases, and destigmatization." In this period, activities focused on preparing ABMS's existing toll-free hotline to answer basic questions on EVD. Implementation will begin in earnest in FY 2016.

Success story

This first quarter of FY 2015 was the exciting beginning of a communications pilot to raise awareness about the dangers of purchasing, using or selling substandard ACTs. To address the lack of information available to vulnerable populations on counterfeit malarial medication, the benefits of seeking medication from reputable pharmacies as well as discourage small businesses from capitalizing illicitly on the large market for malarial drugs, ABMS is leveraging its existing expertise and capacity – its community education programs and media campaigns to educate on these issues. ABMS developed two communications campaigns, exploiting its existing services such as the telephone hotline, their Facebook page, radio and TV spots to disseminate information on these serious issues.

A convoy of motor cycle taxis and cars wove their way through Cotonou on their way to the market bringing more people to listen to the messages.

During the reporting period, ABMS worked with USAID Benin and its office of Inspector General to launch the campaign in collaboration with the Ministry of Health, Ministry of Interior, the Pharmacist Association of Benin, the Mayor of Cotonou, and Dantokpa Market Management Association (SOGEMA). The campaign was launched on November 20th 2014 in the Dantokpa Market by the Minister of

Health, Dr. Gazard, and the US Ambassador, Micheal Raynor. The launch sought to highlight to families purchasing antimalarial medication the advantages of using high quality ACTs, seeking diagnosis with rapid diagnostic tests, and the dangers associated with using such counterfeit medications (principally increasing mortality). In addition, the launch targeted drug vendors in the informal sector to discourage them from selling counterfeit ACTs, or encourage those that are already selling them to abandon the practice by highlighting the dangers they pose to target populations (death and increased drug resistance). The activities surrounding the launch included educational sessions with the police and market vendors to highlight the dangers that fake ACT pose to all Beninese, especially children. To raise awareness of this high level event, a convoy of motorcycle taxis and cars were engaged to attract locals to the event.

Democratic Republic of Congo

The following report highlights the achievements of the SIFPO2 project in the DRC from April 1, 2015 to September 30, 2015. During the reporting period, PSI received funding through both SIFPO1 and SIFPO2 to support common objectives, with SIFPO2 funds supporting primarily HIV activities. This report includes activities conducted under SIFPO2 only.

Objective 1: Increase the availability of quality health services and products related to family planning (FP), maternal and child health (MCH), water, sanitation and hygiene (WASH), and HIV

Under this objective, PSI/ASF focused on increasing access to HIV products and services through the commercial sector and through PSI/ASF's *Confiance* social franchise, comprised of mostly private clinics.

Key Activities

- Distributed HIV products (male and female condoms) under the brands *Prudence Classic, Prudence Sensuel, and Prudence Femme*, through wholesalers and retailers in the project's key provinces.

Results:

- 21,124,123 male condoms (Prudence Classic & Sensual) and 334,634 Female condoms distributed.

Objective 2: Increase knowledge of and demand for health services and products related to FP, MCH, WASH and HIV

Under Objective 2, PSI/ASF focuses on increasing the knowledge of and demand for HIV products and services through social and behavior change communication (SBCC) including IPC and mass media.

Key Activities:

- Delivered HIV messages through IPC by community based educators.
- Published and distributed the *100%Jeune* magazine, aimed at educating youth on SRH and HIV/AIDS, in collaboration with the National Program for Adolescents Health (PNSA).
- Organized *100%Jeune* "Health Walks" in Kinshasa in order to reach more youth with HIV prevention and SRH messages.
- Encouraged youth participation on the *100%Jeune* discussion group on Facebook.
- Organized HIV prevention activities with 11 local NGO partners who were trained under the USAID funded AIDSTAR project (2009-2013).

Results:

- 12,082 *100%Jeune* magazines published.
- 3 "Health Walks" organized, with 1,300 youth in attendance.
- 2,500 members joined the *100%Jeune* discussion group on Facebook.

Table 2: Communication indicators achievement

Indicators	**Achievements (April – Sept. 2015)**
Number of sex workers reached with HIV prevention, counseling and testing information through IPC	1,825
Number of MSMs reached with HIV prevention, counseling and testing information through IPC	194
Number of police officers reached with HIV prevention, counseling and testing information through IPC	1,531
Number of truck drivers reached with HIV prevention, counseling and testing information through IPC	2,209
Number of youth reached with HIV prevention, counseling and testing information through IPC	3,053

Objective 3: Strengthen the capacity of local organizations in behavior change communication, community mobilization and distribution of health products.

No activities were conducted under this objective under SIFPO2 between April and September 2015. Rather, these activities were conducted concurrently under the SIFPO1. Please see the SIFPO1 Annual Report for more details on work carried out under this objective.

Challenges

Main challenges faced by PSI/ASF during the implementation of the SIFPO2 project included:

- A significant number of condoms in PSI's stock (about 16 million) were due to expire in March 2016. Hence, wholesalers were reluctant to buy these condoms and special activities had to be organized to allow for their quick distribution.

Guatemala

The SIFPO2 Guatemala program (locally known as *PlanFam*) aims to reduce maternal mortality and chronic malnutrition by both increasing the use of modern FP methods among rural indigenous women of reproductive age, and by increasing the number of providers who refer to and offer quality, integrated FP and maternal and child health (MCH) services. During this reporting period, activities were mainly carried out in MOH health posts.

Achievements from April 2015 through September 2015 for each result area are as follows:

Result 1: Improve inter-sectoral coordination for FP programs nationwide

PSI/PASMO focuses on improving inter-sectoral coordination for FP programs nationwide by facilitating information sharing, using standardized norms and guidelines for service delivery and advocating for increased FP support at the national and community level.

Under Result 1, PSI/PASMO:

- Monitored the use of national guides for FP services and compliance in 69 health posts.
- Coordinated with the National Contraceptive Security Commission (CNNA) to ensure better monitoring of FP supply and provision. In this period, progress was not made in this area - stockouts continued due to circumstances within the MOH as well as a delay in UNFPA commodities.
- Provided technical assistance to the MOH in the revision and printing of the Perinatal and Neonatal Death Surveillance Guide.

Result 2: Improve access to and quality of FP services

Under this result, PSI/PASMO focuses on building the capacity of providers to offer voluntary FP services and monitored compliance with QA standards. Training and certification activities included:

Activities	April -September 2015
Comprehensive FP Workshops	37
Public sector personnel trained in LARC service delivery	27
Public sector personnel certified in LARC service delivery	29 (two were trained in the previous reporting period)
Compliance visits	124
Anti-stigma and discrimination workshops	15
Anti-stigma and discrimination providers trained	415 (Include personnel the Health Post)

Result Highlight: Within the context of informed choice, 3,598 voluntarily chose a LARC or PM from a range of contraceptive options through *PlanFam*-supported FP service delivery and mobile outreach events by APROFAM, the IPPF Member Association in Guatemala, from April – September 2015.

FP Method	Planfam support to MOH clinics	APROFAM mobile outreach activities (ended in June, 2015)
IUDs	1,097	130
Implants	1,667	1,309
Vasectomy	6	29
Female sterilization	1,461	669
Sub-totals	4,231	2,137
Total	3,598	

PSI/PASMO:

- Monitored compliance with MOH and USAID FP regulations teams (in health posts and APROFAM outreach activities)
- Verified compliance with clinical quality standards through supportive supervision visits among the institutions involved in the intervention: MSPAS, APROFAM, and the NGO WINGS.
- Developed youth-friendly spaces in 10 public sector health facilities.
- Trained 20 service providers to address the SRH needs of youth.

Result 3: Improve FP communication for indigenous women and men

Under this result, PSI/PASMO focused on increasing the demand for LARCs within the context of informed choice through IPC activities and national communication campaigns.

- Seventy IPC agents and coordinators of the PlanFam project were supervised, monitored and evaluated, ensuring the provision of high quality FP information and referrals, through 146 supervisory visits.
- IPC agents implemented promotion activities to create awareness of FP and informed and voluntary demand for FP services; agents also provided accurate information on side effects, as well as advantages and disadvantages of methods, to address method discontinuation.

	April-September 2015
Initial visits	16,394
Follow-up visits	35,976

- Male IPC agents promoted male FP engagement including voluntary vasectomy through various communication activities.
- PSI/PASMO ran the mass media campaign for men "New Masculinity and Family Planning" in printed media and radio. Radio messages were broadcast in Spanish and six Mayan languages. In March 2015, 4,195 spots aired.
- PSI/PASMO trained the MOH in the education-entertainment methodology for youth, "The Events and Experiences of your Life Plan."
- PSI/PASMO developed different communication materials targeting women and men from rural areas (images below).

Malawi

In June 2015, USAID Malawi bought into to SIFPO2 with President's Emergency Plan for AIDS Relief (PEPFAR) resources. The goal of this field support funding in FY 2015 and FY 2016 is to expand HIV services to youth beyond the public sector and increase the number of youth tested and linked to services. USAID is leveraging KfW Development Bank and SIFPO1 investments in PSI/Malawi's work by integrating HIV testing services (HTS) with existing outreach services and the *Tunza* social franchise network. HTS includes pre-test information, post-test counselling, linkages to appropriate HIV prevention, care and treatment services and other clinical and support services. The aim of this approach is to increase the number of youth who are tested and know their HIV status, link youth living with HIV to care and treatment programs, and support risk reduction among youth.

This field support funding also includes activities funded by the USAID Family Health team that will take place in FY 2016:

- continued implementation of youth-friendly health services (YFHS) activities,
- *Youth Alert!* communication activities,
- the provision of commodities to support voluntary FP activities in targeted districts,
- establishment of community-based distribution agents (CBDAs), and
- the addition of one clinical outreach team to Lilongwe district to expand FP method choice.

The SIFPO2 field support funding for Malawi began on June 8, 2015. This report highlights PSI/Malawi's achievements from June 8, 2015 – September 30, 2015 with PEPFAR funds.

Objective 1: Increase enrollment in HIV treatment and care

Under this objective, PSI/Malawi aims to increase uptake of HIV services through the following channels:

I. Offering HTS through private sector social franchise clinics, which provide FP and other integrated health services.
II. Integrating HIV and FP services through the four KfW-funded clinical outreach teams, which provide free FP services in hard to reach areas.
III. Offering HTS and referrals for care through additional outreach teams.

Key Activities and Results:

Recruitment of staff began during the reporting period. The Manager and two nurses joined the project in October 2015. Recruitment of additional outreach nurses, a clinical officer, and HTS counselors will be finalized by the end of November.

Procurement of vehicles, equipment and supplies is in progress following USAID procedures. Most of the equipment (tents, beds, etc.) is expected to be delivered by mid-November. PSI's procurement office advertised a bid for vehicles, collected the quotation and a supplier was identified. The paperwork has been submitted to USAID/Washington and is pending review and approval.

District entry meetings: Meetings with the district health offices for Blantyre, Lilongwe, and Machinga have been undertaken. These meetings were held to inform the respective offices of the launch of new services through different channels. The District Health Teams made plans to involve their staff in quality assurance of PSI/Malawi's HTS work. The program still plans to engage the remaining 7 District Health Offices in the remaining coverage districts. In addition, the program will sensitize various district executive committees throughout the districts. As of September 30, 2015, Machinga was the only district that had completed all district level engagements and begun service provision.

Provision of services: Shortly after the field support funding work plan was finalized, *Tunza* clinics started providing services in July 2015, as most *Tunza* providers were previously trained in HTS under the DFID-HIV Prevention Project. KfW outreach teams have not yet integrated HIV services, as the teams have not been trained in HTS and HIV guidelines on clinical staging. This training is planned for early FY 2016.

In order to begin program implementation quickly, PSI/Malawi mobilized PSI mobile outreach teams from other districts to launch HIV testing services in Machinga district. These providers come from PSI's voluntary medical male circumcision (VMMC) program, which had achieved annual VMMC projections by end August 2015 and were willing to relocate three mobile teams to Machinga to offer HTS outreach in September 2015.

The service delivery results through September 30, 2015, are shown in the table below:

Table 1- HIV service delivery figures for FY15

Indicator	**HIV-Positive**			**HIV-Negative**		
	F	M	Total	F	M	Total
Number of individuals who received HIV testing and counseling services for HIV and received their test results	23	26	49	985	1133	2118
Number of HIV positive adults and children newly enrolled in clinical care during the reporting period who received at least one of the following at enrollment: clinical assessment (WHO staging) OR CD4 count OR viral load	14	10	24	N/A		
Number of adults and children newly enrolled on ART	1	1	2			

Service delivery figures are expected to increase in the next quarter through increased coverage, as staff will be joining the program and HTS will begin in more districts.

The positive yield during the reporting period was 2%, which was lower than expected. The following strategies will be utilized in the next quarter to help the outreach teams increase the positivity rate:

- Collaboration with networks of orphans & vulnerable children (OVCs) in order to test youth in those programs – both young parents as well as older children of parents living with HIV.

- The program will work with Youth Coordinators at the district level to help identify these OVC networks, as well as to identify neighborhoods where young PLHIV live and focus outreach testing in these neighborhoods.
- The program will begin offering more focused index partner testing, focusing on sexual partners of those testing positive in PSI sites.

To address linkages to care, PSI/Malawi will collaborate with partners undertaking linkages, follow-up, psychosocial and adherence support in the communities.

Demand creation: Utilization of community testing was greatly supported by demand creation officers from PSI/Malawi. They worked closely with Health Surveillance Assistance to mobilize people interested in HTS. Demand for HTS in *Tunza* clinics was created through PSI's Targeted Outreach Communication teams. The clinics held special event days for HTS campaigns which the communication teams publicized in communities. In FY 2016, the program will work with IPC officers and assistants to do case finding at the community level.

Quality Assurance (QA): During the reporting period, PSI's QA Officers conducted supportive supervision visits in *Tunza* clinics. Three facilities that are providing HTS under SIFPO2 underwent QA assessments and demonstrated that they are meeting minimum standards. PSI's internal QA team will continue to provide supportive supervision to Tunza and outreach teams in partnership with District Health Teams.

To ensure that data collection is of high quality, PSI/Malawi is revising its internal collection tools to incorporate MOH reporting requirements.

Objective 2: Promote social norms to reduce HIV vulnerability among youth

PSI is expanding the topics addressed within the *YouthAlert! Mix* radio program to include an increased emphasis on HIV and will extend geographic coverage by establishing 100 listener clubs in Lilongwe district. PSI will also expand the network of facilities offering youth-friendly health services (YFHS) to additional *Tunza* clinics. Implementation of this component has not yet started as recruitment of personnel responsible for coordinating listener clubs is underway.

Objective 3: Ensure sustainability of social franchise services

SIFPO2 will begin funding work under Objective 3 in FY 2016, continuing activities that were previously funded by SIFPO1. Currently, KfW and USAID (through SIFPO1) are co-funding a sustainability assessment of the *Tunza* franchise business model. An external consultant has completed an initial assessment of the franchise model and will provide clear guidance to PSI on how the *Tunza* franchise model can be modified to ensure financial viability and sustainability of the franchise.

Challenges

Due to the timing of work plan approval, most of FY 2015 was dedicated to program start up activities (e.g., procurement, staff recruitment, stakeholder engagement and district entry meetings). Delays in recruitment of personnel, district meeting schedules, and the procurement of required equipment for service delivery have affected the feasibility of delivering on HTS targets within the agreed timeline. Through the HTS outreach teams, PSI will increase the number of service providers at an outreach clinic

to shorten the waiting period for clients, addressing a barrier to HTS. PSI is in discussion with the Mission about updating HTS targets for FY16.

Positivity and linkage rates were lower than anticipated. The targeting strategies stated under objective 1 will be implemented and assessed in the next reporting period in order to improve the positivity rate. HTS staff and PSI management will hold weekly performance review meetings on positivity rates in testing in order to continuously improve HTS strategies. PSI will ensure that all HTS delivery points have a clinical staging provider for easy linkage to care in health facilities. Service delivery teams will dedicate other personnel to follow-up and tracing of positive clients.

Year One Budget Summary

Result Area	Expenditures through September 2015
Result 1: Strengthen the capacity of PSI's network of members to deliver high-quality FP and other health services to target groups	$1,357,608
Result 2: Increase the sustainability of country level FP and other health programs	$1,043,134
Subtotal: Core	**$2,400,741**
Benin Mission	$83,951
DRC Mission	$400,000
Guatemala Mission	$974,276
Malawi Mission	$105,211
Subtotal: Missions*	**$1,563,439**
Grand Total	**$3,964,180**

** Cambodia and Ghana have received obligations, but did not have expenditures during this reporting period. PSI's subaward to PS Khmer in Cambodia was approved in September 2015 and any start-up expenses will be included in the next report. The Ghana work plan is still in development.*